PPO - NON-GRANDFATHERED

GILSTER-MARY LEE CORPORATION
GROUP HEALTH BENEFIT PLAN

Plan Document and Summary Plan Description
Effective: January 1, 2013
Restated: January 1, 2018

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ARTICLE I
ESTABLISHMENT OF THE PLAN; ADOPTION OF THE PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

THIS PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION, made by Gilster-Mary Lee Corporation (the "Company" or the "Plan Sponsor") as of January 1, 2018, hereby **amends and restates** the Gilster-Mary Lee Corporation Group Health Benefit Plan (the "Plan"), which was originally adopted by the Company, effective January 1, 2013.

1.01 Effective Date

The Plan Document is effective as of the date first set forth above, and each amendment is effective as of the date set forth therein.

1.02 Adoption of the Plan Document

The Plan Sponsor, as the settlor of the Plan, hereby adopts this Plan Document as the written description of the Plan. This Plan Document represents both the Plan Document and the Summary Plan Description, which is required by the Employee Retirement Income Security Act of 1974, 29 U.S.C. et seq. ("ERISA"). This Plan Document amends and replaces any prior statement of the health care coverage contained in the Plan or any predecessor to the Plan.

IN WITNESS WHEREOF, the Plan Sponsor has caused this Plan Document to be executed.

Gilster-Mary Lee Corporation

By: _____

Name: STEVE LANDHOLT

Date: 4/2/2018

Title: BENEFITS MANAGER

ARTICLE II
INTRODUCTION AND PURPOSE; GENERAL PLAN INFORMATION

2.01 Introduction and Purpose

The Plan Sponsor has established the Plan for the benefit of eligible Employees, in accordance with the terms and conditions described herein. Plan benefits may be self-funded through a benefit fund or a trust established by the Plan Sponsor and self-funded with contributions from Participants and/or the Plan Sponsor, or may be funded solely from the general assets of the Plan Sponsor. Participants in the Plan may be required to contribute toward their benefits.

The Plan Sponsor's purpose in establishing the Plan is to help offset, for eligible Employees, the economic effects arising from a Non-occupational Injury or Sickness. To accomplish this purpose, the Plan Sponsor must be cognizant of the necessity of containing health care costs through effective plan design, and of abiding by the terms of the Plan Document, to allow the Plan Sponsor to allocate the resources available to help those individuals participating in the Plan to the maximum feasible extent.

The purpose of this Plan Document is to set forth the terms and provisions of the Plan that provide for the payment or reimbursement of all or a portion of certain expenses for hospital, medical, prescription or dental charges. The Plan Document is maintained by the Company and may be inspected at any time during normal working hours by any Participant.

2.02 General Plan Information

Name of Plan:	**Gilster-Mary Lee Corporation Group Health Benefit Plan**
Plan Sponsor:	**Gilster-Mary Lee Corporation** **1037 State Street** **Chester, IL 62233** **618-826-2361**
Plan Administrator: **(Named Fiduciary)**	**Gilster-Mary Lee Corporation** **1037 State Street** **Chester, IL 62233** **618-826-2361**
Plan Sponsor ID No. (EIN):	**37-0951425**
Plan Status:	**Non-Grandfathered**
Source of Funding:	**Self-Funded**
Applicable Law:	**ERISA**
Plan Year:	**January 1 through December 31**
Plan Number:	**501**
Plan Type:	**Medical** **Dental** **Prescription Drug**
Third Party Administrator:	**HealthSCOPE Benefits, Inc.** **27 Corporate Hill Drive** **Little Rock, AR 72205** **501-225-1551**

Participating Employer(s):	**Gilster-Mary Lee Corporation**
Agent for Service of Process:	**Gilster-Mary Lee Corporation** **Plan Administrator** **1037 State Street** **Chester, IL 62233** **618-826-2361**

2.03 Legal Entity; Service of Process

The Plan is a legal entity. Legal notice may be filed with, and legal process served upon, the Plan Administrator.

2.04 Not a Contract

This Plan Document and any amendments constitute the terms and provisions of coverage under this Plan. The Plan Document shall not be deemed to constitute a contract of any type between the Company and any Participant or to be consideration for, or an inducement or condition of, the employment of any Employee. Nothing in this Plan Document shall be deemed to give any Employee the right to be retained in the service of the Company or to interfere with the right of the Company to discharge any Employee at any time; provided, however, that the foregoing shall not be deemed to modify the provisions of any collective bargaining agreements which may be entered into by the Company with the bargaining representatives of any Employees.

2.05 Mental Health Parity

Pursuant to the Mental Health Parity Act (MHPA) of 1996 and the Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008, collectively, the mental health parity provisions in Part 7 of ERISA, this Plan applies its terms uniformly and enforces parity between covered health care benefits and covered mental health and substance disorder benefits relating to financial cost sharing restrictions and treatment duration limitations. For further details, please contact the Plan Administrator.

2.06 Applicable Law

This is a self-funded benefit plan coming within the purview of the Employee Retirement Income Security Act of 1974 ("ERISA"). The Plan is funded with employee and/or employer contributions. As such, when applicable, Federal law and jurisdiction preempt State law and jurisdiction.

2.07 Discretionary Authority

The Plan Administrator shall have sole, full and final discretionary authority to interpret all Plan provisions, including the right to remedy possible ambiguities, inconsistencies and/or omissions in the Plan and related documents; to make determinations in regards to issues relating to eligibility for benefits; to decide disputes that may arise relative to a Plan Participants' rights; and to determine all questions of fact and law arising under the Plan.

ARTICLE III
SUMMARY OF BENEFITS

3.01 General Limits

Payment for any of the expenses listed below is subject to all Plan exclusions, limitations and provisions. All coverage figures are after the out-of-pocket Deductible has been satisfied. Benefits for Pregnancy expenses, are paid the same as any other Sickness.

Failure to comply with Utilization Management will result in a higher cost to Participants. **"Utilization Management"** includes hospital pre-admission certification, continued stay review, length-of-stay determination and discharge planning. These programs are designed to ensure that Medically Necessary, high-quality patient care is provided and enables maximum benefits under the Plan. See pre-certification requirements in the section entitled "Cost Containment."

The following services will require pre-certification (or reimbursement from the Plan may be reduced):

Inpatient Services

- Cervical Spine Surgery
- Computer Navigation for Orthopedic Surgery
- Elective Admissions
- Emergency Admissions
- Hospice
- Long-Term Acute Care Admissions
- Lumbar Spine Surgery
- Rehabilitation Facility Admissions
- Skilled Nursing Facility Admissions
- Transplants

Surgical Procedures

- Cartilage Transplant Knee
- Cervical Spine Surgery
- Cochlear Implant
- Computer Navigation for Orthopedic Surgery
- Lumbar Spine Surgery
- Nasal Septoplasty
- Rhinoplasty
- Sinus Endoscopy
- Sleep Apnea Surgery – LAUP/UPPP, Nasal and Uvulopalatoplasty

Ancillary Services

- Air Ambulance
- Home Infusion Services
- Home Health Services
- Home Hospice
- Occupational Therapy
- Physical Therapy
- Speech Therapy

Durable Medical Equipment

- Bone Stimulator
- Cardio/External Defibrillator
- Cooling Devices
- CPAP/BiPAP
- Electric Scooters
- Limb Prosthetics
- Myoelectric Prosthetics
- Neuromuscular Stimulators
- TENS Unit
- Wheelchairs (Custom)
- Wheelchairs (Power)
- Wound Vacs

Diagnostic Imaging – Ambulatory

- Coronary CT Angiography (CCTA)
- Coronary MRA
- Cardiac MRI
- MRA of the Head and/or Neck
- MRI of the Brain
- MRI of Spine – Cervical, Thoracic, Lumbar, Sacral
- PET Scans

Specialty Infusion Drugs

- Alemtuzumab (Campath)
- Azacitidine (Vidaza)
- Bevacizumab (Avastin)
- Bortezomib (Velcade)
- Fulvestrant (Faslodex)
- Immune Globulin (Intravenous)
- Infliximab (Remicade)
- Mitaxantrone (Novantrone)
- Oxaliplatin (Eloxatin)
- Paclitaxel (Taxol and Abraxane)
- Panitumubab (Vectibix)
- Pemetrexed (Alimta)
- Rituximab (RituXan)
- Trastuzumab (Herceptin)
- Zoledronic Acid (Zometa)

Please note: These services refer only to services requiring pre-certification by the Plan's network. The Plan may or may not provide benefits for the services listed. The examples provided are not all-inclusive. Please contact the customer service number listed on the ID card for more information.

Remember that although the Plan will automatically pre-authorize a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours for a cesarean delivery, it is important to have your Physician call to obtain pre-certification in case there is a need to have a longer stay.

See pre-certification requirements in the section entitled "Cost Containment" for more details.

The Plan contracts with the medical provider Networks to access discounted fees for service for Participants. Hospitals, Physicians and other Providers who have contracted with the medical provider Networks are called "Network Providers." Those who have not contracted with the Networks are referred to in this Plan as "Non-Network Providers." This arrangement results in the following benefits to Participants:

1. The Plan provides different levels of benefits based on whether the Provider Participants use a Network or Non-Network Provider. Unless one of the exceptions shown below applies, if a Participant elects to receive medical care from the Non-Network Provider, the benefits payable are generally lower than those payable when a Network Provider is used. The following exceptions apply:

    a. In the event a Network Provider refers a Participant to a non-Network Provider for diagnostic testing, x-rays, laboratory services or anesthesia, then charges of the non-Network Provider will be paid as though the services were provided by a Network Provider.
    b. The Network Provider level of benefits is payable when a Participant receives emergency care either Out of Area or at a Non-Network Hospital for an Accidental Bodily Injury or Emergency.

2. If the charge billed by a Non-Network Provider for any covered service is higher than the Usual and Customary Fees determined by the Plan, Participants are responsible for the excess unless the Provider accepts assignment of benefits as consideration in full for services rendered. Since Network Providers have agreed to accept a negotiated discounted fee as full payment for their services, Participants are not responsible for any billed amount that exceeds that fee.

3. To receive benefit consideration, Participants must submit claims for services provided by Non-Network Providers to the Third Party Administrator. Network Providers have agreed to bill the Plan directly, so that Participants do not have to submit claims themselves.

4. Benefits available to Network Providers are limited such that if a Network Provider advances or submits charges which exceed amounts that are eligible for payment in accordance with the terms of the Plan, or are for services or supplies for which Plan coverage is not available, or are otherwise limited or excluded by the Plan, benefits will be paid in accordance with the terms of the Plan.

5. Claims for services rendered by Auburn Surgical Center and St. Francis Medical Center will be processed at the Non-Network benefit level. Claims for services rendered by Midwest Surgical Center will be excluded.

A current list of PPO Providers is available, without charge, through the Third Party Administrator's website (located at www.healthscopebenefits.com). If you have any questions about how to do this, contact the Human Relations Department.

Each Participant has a free choice of any physician or surgeon, and the physician-patient relationship shall be maintained. The Participant, together with his or her physician, is ultimately responsible for determining the appropriate course of medical treatment, regardless of whether the Plan will pay for all or a portion of the cost of such care. The PPO providers are merely independent contractors; neither the Plan nor the Plan Administrator make any warranty as to the quality of care that may be rendered by any PPO provider.

3.02 Primary Care Providers

A current list of PPO providers is available, without charge, through the Third Party Administrator's website (located at www.healthscopebenefits.com).

Each Participant has a free choice of any physician or surgeon, and the physician-patient relationship shall be maintained. The Participant, together with his or her Physician, is ultimately responsible for determining the appropriate course of medical treatment, regardless of whether the Plan will pay for all or a portion of the cost of such care. The PPO providers are merely independent contractors; neither the Plan nor the Plan Administrator make any warranty as to the quality of care that may be rendered by any PPO provider.

3.03 Claims Audit

In addition to the Plan's Medical Record Review process, the Plan Administrator may use its discretionary authority to utilize an independent bill review and/or claim audit program or service for a complete claim. While every claim may not be subject to a bill review or audit, the Plan Administrator has the sole discretionary authority for selection of claims subject to review or audit.

The analysis will be employed to identify charges billed in error and/or charges that are not Usual and Customary and/or Medically Necessary and Reasonable, if any, and may include a patient medical billing records review and/or audit of the patient's medical charts and records.

Upon completion of an analysis, a report will be submitted to the Plan Administrator or its agent to identify the charges deemed in excess of the Usual and Customary and Reasonable amounts or other applicable provisions, as outlined in this Plan Document.

Despite the existence of any agreement to the contrary, the Plan Administrator has the discretionary authority to reduce any charge to a Usual and Customary and Reasonable charge, in accord with the terms of this Plan Document.

3.04 Calendar Year Maximum Benefit

The following calendar year maximums apply to each Participant:

Calendar Year Maximum Benefits for:	
Cardiac Rehabilitation	36 Visits
Chiropractic Care	10 Visits
Occupational Therapy	10 Visits
Physical Therapy	15 Visits
Speech Therapy	10 Visits
All Essential Health Benefits	Unlimited

3.05 Summary of Medical Benefits

The following benefits are per Participant per calendar year:

	Network	Non-Network
Deductible • Individual • Employee + 1 • Family Unit	 $1,000 $2,000 $3,000	 $5,000 $10,000 $15,000
	Eligible expenses will cross apply to the Network and Non-Network Deductibles. The Employee + 1 Deductible will be met when 2 family members meet the Individual Deductible amount. The Family Unit Deductible will be met when 3 family members the Individual Deductible amount.	
Payment Level (unless otherwise stated)	80%	60%
Maximum Out-of-Pocket • Individual • Employee + 1 or Family Unit	 $6,600 $13,200	 $25,000 $75,000
	Deductible, copayment, coinsurance and prescription expenses apply to the Network Out-of-Pocket Maximum. Excluded charges, amounts over Usual and Customary Fees and penalties are not included. Network Employee + 1 and Family coverage includes an embedded Individual Maximum Out-of-Pocket.	

Covered Medical Expenses:	Network	Non-Network
1. Allergy Services • Office Visit • Injections • Serum	 80% after Deductible 80% after Deductible 80% after Deductible	 60% after Deductible 60% after Deductible 60% after Deductible
2. Ambulance	80% after Deductible	60% after Deductible
	Transport by a Non-Network ambulance to a Network facility will be paid at the Network rate and applied to the Network Deductible.	
3. Ambulatory Surgical Center	80% after Deductible	60% after Deductible
4. Anesthesia	80% after Deductible	60% after Deductible
5. Birthing Center	80% after Deductible	60% after Deductible
6. Cardiac Rehabilitation	80% after Deductible	60% after Deductible
	Phase I, II and III are covered. Limited to 36 visits.	
7. Chiropractic Care	80% after Deductible	60% after Deductible
	Limited to 10 visits per year.	
8. Dental Services	80% after Deductible	60% after Deductible
	Includes treatment due to accidental injury is covered if completed within 12 months of accident and outpatient surgical removal of full bony impacted teeth is covered.	
9. Dialysis Treatment - Outpatient	100% of the Usual and Reasonable Charge after all applicable deductibles and coinsurance	
	Pre-certification is required. Please refer to Dialysis Treatment Outpatient Description in section 15.01(12).	
10. Durable Medical Equipment	80% after Deductible	60% after Deductible
	Pre-certification is required for equipment over $2,000. Includes rental not exceeding the purchase price, routine maintenance, repair, and replacement if necessary due to the Participant's growth and development.	
11. Educational Services	80% after Deductible	60% after Deductible
	Includes educational instruction for diabetes, ostomy and obesity weight loss.	
12. Glaucoma, Cataract Surgery and Lenses (one set)	80% after Deductible	60% after Deductible
13. Home Health Care	80% after Deductible	60% after Deductible

14. Hospice Care • Inpatient • Outpatient • Family Bereavement Counseling	80% after Deductible 80% after Deductible 80% after Deductible	60% after Deductible 60% after Deductible 60% after Deductible
	Pre-certification is required. Respite care is not covered.	
15. Hospital • Inpatient Treatment • Outpatient Treatment	80% after Deductible 80% after Deductible	60% after Deductible 60% after Deductible
	Pre-certification is required for inpatient treatment.	
16. Impregnation and Infertility Treatment	80% after Deductible	60% after Deductible
	Limited to maximum benefit of $10,000 for medical and prescription costs combined per lifetime. See section 15.01(20) for details.	
17. Newborn Care	80% after Deductible	60% after Deductible
	Charges for newborn children of a Dependent Child will not be covered.	
18. Obesity Services	80% after Deductible	60% after Deductible
	Pre-certification is required. Includes 1 surgical treatment per lifetime. Covered surgeries include: gastroplasty; initial Lap Band placement; Lap Band replacement; Lap Band removal, Lap Band adjustment; gastric bypass; gastric stapling and panniculectomy. See section 15.01(25) for eligibility.	
19. Outpatient Diagnostic X-ray and Lab	80% after Deductible	60% after Deductible
20. Outpatient Emergency Services – Emergency Room • Emergency • Non-Emergency	$200 copay 80% after Deductible	$200 copay 60% after Deductible
	Copay is waived if patient is admitted to the hospital.	
21. Physician Services • Office Visit • Lab, x-rays and Surgery	$25 copay 80% after Deductible	60% after Deductible 60% after Deductible
	The Network office visit copay for Physician and Urgent Care visits will be applied up to 4 times per plan year. Office visits in excess of 4 visits will be subject to deductible and coinsurance.	
22. Podiatry Services	80% after Deductible	60% after Deductible
	Does not include care resulting from weak, strained, unstable, unbalanced or flat feet; metarsalgia or bunions, unless an open cutting operation is performed; or treatment of corns, calluses or toenails, unless at least part of the nail root is removed or care is necessary for metabolic or peripheralvascular disease.	
23. Pregnancy Expenses	80% after Deductible	60% after Deductible
24. Preventive Care	100% no Deductible	60% after Deductible
	See section 15.01(33) for covered preventive services.	
25. Private Duty Nursing	80% after Deductible	60% after Deductible
26. Prosthetics, Orthotics, Supplies and Surgical Dressings	80% after Deductible	60% after Deductible
	Includes routine maintenance, repair, and replacement if necessary due to the Participant's natural growth and development. Custom molded are covered when required for an acquired deformity of the foot. Palliative treatment for pain is covered except for heel lifts, arch supports and foot pads. Corrective or orthopedic shoes are covered when attached to a brace.	
27. Mental Health Expenses • Inpatient Treatment • Outpatient Treatment	80% after Deductible 80% after Deductible	60% after Deductible 60% after Deductible
	Pre-certification is required for inpatient treatment. The Network office visit copay will be applied up to 4 times per plan year. Office visits in excess of 4 will be subject to deductible and coinsurance. Pre-certification is required for impatient treatment	
28. Second Surgical Opinions	100% no Deductible	100% no Deductible
29. Skilled Nursing Facility	80% after Deductible	60% after Deductible
	Pre-certification is required. Must follow hospital confinement of at least 3 days and begin no more than 14 days after confinement has ended.	

30. Substance Abuse Benefits • Inpatient Treatment • Outpatient Treatment	80% after Deductible 80% after Deductible	 60% after Deductible 60% after Deductible
	The Network office visit copay will be applied up to 4 times per plan year. Office visits in excess of 4 will be subject to deductible and coinsurance. Pre-certification is required for impatient treatment	
31. Surgery	80% after Deductible	60% after Deductible
32. Temporomandibular Joint Disorder (TMJ)	80% after Deductible	60% after Deductible
33. Therapy • Occupational Therapy • Physical Therapy • Speech Therapy	 80% after Deductible 80% after Deductible 80% after Deductible	 60% after Deductible 60% after Deductible 60% after Deductible
	Pre-certification is required. Occupational and Speech Therapy are limited to 10 visits per calendar year. Physical Therapy is limited to 15 visits per calendar year.	
34. Transplants	100% no Deductible	Not covered
	The Transplant Network must be utilized. Does not include transportation, meals and lodging expenses.	
35. Urgent Care Facility & Physician • Office Visit • All Other Services	 $25 copay 80% after Deductible	 60% after Deductible 60% after Deductible
	The Network office visit copay for Physician and Urgent Care visits will be applied up to 4 times per plan year. Office visits in excess of 4 visits will be subject to deductible and coinsurance.	
36. Wigs	80% after Deductible	80% after Deductible
	Limited to 1 wig every 5 years up to a maximum of $300. Covered for hair loss due to chemotherapy/radiation or scalp burns.	

3.06 Summary of Dental Benefits

The following Deductibles, maximums and benefits are per Participant. See Article XVI for eligibility requirements:

Maximum benefit per calendar year for Class 1, 2 and 3 Services	$200

Covered Dental Expenses:	**Benefits**
Class 1 Services (Preventive Care)	80%
Class 2 Services (Repair and Restoration)	80%
Class 3 Services (Major Dental Repair)	80%
Charges are limited to Usual and Customary Fees.	

3.07 Summary of Prescription Drug Benefits

The following benefits are per Participant:

Covered Prescription Drug Expenses:	**Participating Pharmacy**
Pharmacy Option:	
Copayment, per prescription or refill, for generic	20% coinsurance $5 minimum, $25 maximum
Copayment, per prescription or refill, for formulary name brands	20% coinsurance $25 minimum, $50 maximum
Copayment, per prescription or refill, for non-formulary name brands	20% coinsurance $40 minimum, $75 maximum
Mail Order Option:	
Copayment, per prescription or refill, for generic	20% coinsurance $15 minimum, $75 maximum
Copayment, per prescription or refill, for formulary name brands	20% coinsurance $65 minimum, $130 maximum
Copayment, per prescription or refill, for non-formulary name brands	20% coinsurance $100 minimum, $175 maximum
Specialty Drugs (30-day supply): Copayment, per prescription or refill	$100 copay

ARTICLE IV
DEFINITIONS

The following words and phrases shall have the following meanings when used in the Plan Document. **The following definitions are not an indication that charges for particular care, supplies or services are eligible for payment under the Plan, however they may be used to identify ineligible expenses; please refer to the appropriate sections of the Plan Document for that information.**

"Accident"
"Accident" shall mean a sudden and unforeseen event, or a deliberate act resulting in unforeseen consequences.

"Accidental Bodily Injury"
"Accidental Bodily Injury" shall mean an Injury sustained as the result of an Accident and independently of all other causes by an outside traumatic event or due to exposure to the elements.

"ADA"
"ADA" shall mean the American Dental Association.

"Adverse Benefit Determination"
"Adverse Benefit Determination" shall mean any of the following:

1. A denial in benefits;
2. A reduction in benefits;
3. A rescission of coverage;
4. A termination of benefits; or
5. A failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Claimant's eligibility to participate in the Plan.

"Affordable Care Act (ACA)"
The "Affordable Care Act (ACA)" means the health care reform law enacted in March 2010. The law was enacted in two parts: the Patient Protection and Affordable Care Act was signed into law on March 23, 2010 and was amended by the Health Care and Education Reconciliation Act on March 30, 2010. The name "Affordable Care Act" is commonly used to refer to the final, amended version of the law. In this document, the Plan uses the name Affordable Care Act (ACA) to refer to the health care reform law.

"AHA"
"AHA" shall mean the American Hospital Association.

"Allowable Expenses"
"Allowable Expenses" shall mean the Maximum Allowable Charge for any Medically Necessary, eligible item of expense, at least a portion of which is covered under a plan. When some Other Plan pays first in accordance with the Application to Benefit Determinations provision in the Coordination of Benefits section, this Plan's Allowable Expenses shall in no event exceed the Other Plan's Allowable Expenses.

When some Other Plan provides benefits in the form of services rather than cash payments, the Plan Administrator shall assess the value of said benefit(s) and determine the reasonable cash value of each service rendered, by determining the amount that would be payable in accordance with the terms of the Plan, shall be deemed to be the benefit. Benefits payable under any Other Plan include the benefits that would have been payable had claim been duly made therefore, whether or not it is actually made.

"Alternate Recipient"
"Alternate Recipient" shall mean any Child of a Participant who is recognized under a Medical Child Support Order as having a right to enrollment under this Plan as the Participant's Eligible Dependent. For purposes of the benefits provided under this Plan, an Alternate Recipient shall be treated as an Eligible Dependent, but for purposes of the

reporting and disclosure requirements under ERISA, an Alternate Recipient shall have the same status as a Participant.

"AMA"
"AMA" shall mean the American Medical Association.

"Ambulatory Surgical Center"
"Ambulatory Surgical Center" shall mean any public or private State licensed and approved (whenever required by law) establishment with an organized medical staff of Physicians, with permanent facilities that are equipped and operated primarily for the purpose of performing Surgical Procedures, with continuous Physician services and registered professional nursing service whenever a patient is in the facility, and which does not provide service or other accommodations for patients to stay overnight.

"Approved Clinical Trial"
"Approved Clinical Trial" means a phase I, II, III or IV trial that is federally funded by specified Agencies (National Institutes of Health, CDCP, Agency for Health Care Research, CMS, Dept. of Defense or Veterans Affairs, or a non-governmental entity identified by NIH guidelines) or is conducted under an Investigational new drug application reviewed by the FDA (if such application is required).

The Affordable Care Act requires that if a "qualified individual" is in an "Approved Clinical Trial," the Plan cannot deny coverage for related services ("routine patient costs").

A "qualified individual" is someone who is eligible to participate in an "Approved Clinical Trial" and either the individual's doctor has concluded that participation is appropriate or the Participant provides medical and scientific information establishing that their participation is appropriate.

"Routine patient costs" include all items and services consistent with the coverage provided in the plan that is typically covered for a qualified individual who is not enrolled in a clinical trial. Routine patient costs do not include 1) the Investigational item, device or service itself; 2) items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and 3) a service that is clearly inconsistent with the widely accepted and established standards of care for a particular Diagnosis. Plans are not required to provide benefits for routine patient care services provided outside of the Plan's Network area unless out-of-network benefits are otherwise provided under the Plan.

"Assignment of Benefits"
"Assignment of Benefits" shall mean an arrangement whereby the Plan Participant assigns their right to seek and receive payment of eligible Plan benefits, in strict accordance with the terms of this Plan Document, to a Provider. If a provider accepts said arrangement, Providers' rights to receive Plan benefits are equal to those of a Plan Participant, and are limited by the terms of this Plan Document. A Provider that accepts this arrangement indicates acceptance of an "Assignment of Benefits" as consideration in full for services, supplies, and/or treatment rendered.

"Birthing Center"
"Birthing Center" shall mean a facility that meets professionally recognized standards and all of the following requirements:

1. It mainly provides an outpatient setting for childbirth following a normal, uncomplicated Pregnancy, in a home-like atmosphere.
2. It has the following: at least 2 delivery rooms; all the medical equipment needed to support the services furnished by the facility; laboratory diagnostic facilities; and emergency equipment, trays, and supplies for use in life threatening situations.
3. It has medical staff that: is supervised by a Physician on a full-time basis; and includes a Registered Nurse at all times when Covered Persons are at the facility.
4. If it is not part of a Hospital, it has a written agreement with a local Hospital and a local ambulance company for the immediate transfer of Covered Persons who develop complications or who require either pre or post-natal care.

5. It admits only Covered Persons who: have undergone an educational program to prepare them for the birth; and have medical records of adequate prenatal care.
6. It schedules confinements of not more than 24 hours for a birth.
7. It maintains medical records for each Covered Person.
8. It complies with all licensing and other legal requirements that apply.
9. It is not the office or clinic of one or more Physicians or a specialized facility other than a Birthing Center.

"Break in Service"
"Break in Service" means a period of at least 13 consecutive Weeks during which the Employee has no Hours of Service, as defined herein. A Break in Service may also include any period for which the Employee has no Hours of Service that is at least four (4) consecutive Weeks in duration and longer than the prior period of employment (determined after application of the procedures applicable to Special Unpaid Leaves absence prescribed herein).

"Cardiac Care Unit"
"Cardiac Care Unit" shall mean a separate, clearly designated service area which is maintained within a Hospital and which meets all the following requirements:

1. It is solely for the treatment of patients who require special medical attention because of their critical condition;
2. It provides within such area special nursing care and observation of a continuous and constant nature not available in the regular rooms and wards of the Hospital;
3. It provides a concentration of special lifesaving equipment immediately available at all times for the treatment of patients confined within such area;
4. It contains at least two beds for the accommodation of critically ill patients; and
5. It provides at least one professional registered nurse, who continuously and constantly attends the patient confined in such area on a 24-hour-a-day basis.

"Centers of Excellence"
"Centers of Excellence" shall mean medical care facilities that have met stringent criteria for quality care in the specialized procedures of organ transplantation. These centers have the greatest experience in performing transplant procedures and the best survival rates. The Plan Administrator shall determine what Network Centers of Excellence are to be used.

Any Participant in need of an organ transplant may contact the Claims Administrator to initiate the pre-certification process resulting in a referral to a Center of Excellence. The Claims Administrator acts as the primary liaison with the Center of Excellence, patient and attending Physician for all transplant admission taking place at a Center of Excellence.

If a Participant chooses not to use a Center of Excellence, the payment for services will be limited to what would have been the cost at the nearest Center of Excellence.

Additional information about this option, as well as a list of Centers of Excellence, will be given to covered Employees and updated as requested.

"Certificate of Coverage"
"Certificate of Coverage" shall mean a written certification provided by any source that offers medical care coverage, including the Plan, for the purpose of confirming the duration and type of an individual's previous coverage.

"Child"
"Child" shall mean, in addition to the Employee's own blood descendant of the first degree or lawfully adopted Child, a Child placed with a covered Employee in anticipation of adoption, a covered Employee's Child who is an alternate recipient under a Qualified Medical Child Support Order as required by the Federal Omnibus Budget Reconciliation Act of 1993, any stepchild, an "eligible foster child," which is defined as an individual placed with

the Employee by an authorized placement agency or by judgment, decree or other order of a court of competent jurisdiction or any other Child for whom the Employee has obtained legal guardianship.

"CHIP"
"CHIP" refers to the Children's Health Insurance Program or any provision or section thereof, which is herein specifically referred to, as such act, provision or section may be amended from time to time.

"CHIPRA"
"CHIPRA" refers to the Children's Health Insurance Program Reauthorization Act of 2009 or any provision or section thereof, which is herein specifically referred to, as such act.

"Chiropractic Care"
"Chiropractic Care" shall mean office visits, x-rays, manipulations, supplies, heat treatment, and cold treatment.

"Claim Determination Period"
"Claim Determination Period" shall mean each calendar year.

"Clean Claim"
A "Clean Claim" is one that can be processed in accordance with the terms of this document without obtaining additional information from the service Provider or a third party. It is a claim which has no defect or impropriety. A defect or impropriety shall include a lack of required sustaining documentation as set forth and in accordance with this document, or a particular circumstance requiring special treatment which prevents timely payment as set forth in this document, and only as permitted by this document, from being made. A Clean Claim does not include claims under investigation for fraud and abuse or claims under review for Medical Necessity and Reasonableness, or fees under review for Usual and Customariness, or any other matter that may prevent the charge(s) from being covered expenses in accordance with the terms of this document.

Filing a Clean Claim. A Provider submits a Clean Claim by providing the required data elements on the standard claims forms, along with any attachments and additional elements or revisions to data elements, attachments and additional elements, of which the Provider has knowledge. The Plan Administrator may require attachments or other information in addition to these standard forms (as noted elsewhere in this document and at other times prior to claim submittal) to ensure charges constitute covered expenses as defined by and in accordance with the terms of this document. The paper claim form or electronic file record must include all required data elements and must be complete, legible, and accurate. A claim will not be considered to be a Clean Claim if the Plan Participant has failed to submit required forms or additional information to the Plan as well.

"COBRA"
"COBRA" shall mean the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

"Cosmetic Surgery"
"Cosmetic Surgery" shall mean any Surgery, service, Drug or supply designed to improve the appearance of an individual by alteration of a physical characteristic which is within the broad range of normal but which may be considered unpleasing or unsightly, except when necessitated by an Injury.

"Covered Expense"
"Covered Expense" means a Usual and Customary fee for a Reasonable, Medically Necessary service, treatment or supply, meant to improve a condition or participant's health, which is eligible for coverage in this Plan. Covered Expenses will be determined based upon all other Plan provisions. When more than one treatment option is available, and one option is no more effective than another, the Covered Expense is the least costly option that is no less effective than any other option.

All treatment is subject to benefit payment maximums shown in the Summary of Benefits and as determined elsewhere in this document.

"Covered Mental Health Service Providers"
"Covered Mental Health Service Providers" are physicians and associated visits which are limited and subject to the Summary of Benefits and terms of this document. Psychiatrists (M.D.), psychologists (Ph.D.) or counselors licensed to provide individual psychotherapy without supervision in the State they are practicing, may bill the Plan directly. Other licensed mental health practitioners must be under the direction of and must bill the Plan through these professionals.

"Creditable Coverage"
"Creditable Coverage" shall mean coverage of an individual under any of the following: a group health plan, health insurance coverage, Medicare, Medicaid (other than coverage consisting solely of benefits under the program for distribution of pediatric vaccines), medical and dental care for members and certain former members of the Uniformed Services and their dependents, a medical care program of the Indian Health Service or a tribal organization, a State health benefits risk pool, a health plan offered under the Federal Employees Health Benefits Program, a public health plan, or a health benefit plan under Section 5(e) of the Peace Corps Act, or Title XXI of the Social Security Act (State Children's Health Insurance Program). To the extent that further clarification is needed with respect to the sources of Creditable Coverage listed in the prior sentence, please see the complete definition of Creditable Coverage that is set forth in 45 C.F.R. § 146.113(a).

"Custodial Care"
"Custodial Care" shall mean care or confinement provided primarily for the maintenance of the Participant, essentially designed to assist the Participant, whether or not Totally Disabled, in the activities of daily living, which could be rendered at home or by persons without professional skills or training. This care is not reasonably expected to improve the underlying medical condition, even though it may relieve symptoms or pain. Such care includes, but is not limited to, bathing, dressing, feeding, preparation of special diets, assistance in walking or getting in and out of bed, supervision over medication which can normally be self-administered and all domestic activities.

"Deductible"
"Deductible" shall mean an amount of money that is paid once a calendar year per Participant and Family Unit. Typically, there is one Deductible amount per Plan and it must be paid before any money is paid by the Plan for any covered services. Each calendar year, a new Deductible amount is required. Eligible expenses incurred in the last 3 months of the calendar year will carry forward and be applied to the Deductible of the following calendar year.

"Dentist"
"Dentist" shall mean an individual holding a D.D.S. or D.M.D. degree, licensed to practice dentistry in the jurisdiction where such services are provided.

"Dependent"
"Dependent" shall mean one or more of the following person(s):

1. An Employee's lawfully married spouse possessing a marriage license who is not divorced from the Employee. For purposes of this section, "marriage or married" means a legal union between a couple of the same or opposite sex, but excludes domestic partnerships and common law marriages;
2. An Employee's Child who is less than 26 years of age. Coverage shall continue through the end of the month in which the Child reaches age 26; and
3. An Employee's Child, regardless of age, who was continuously covered prior to attaining the limiting age under the bullets above, who is mentally or physically incapable of sustaining his or her own living. Such Child must have been mentally or physically incapable of earning his or her own living prior to attaining the limiting age under the bullets above. Written proof of such incapacity and dependency satisfactory to the Plan must be furnished and approved by the Plan within 31 days after the date the Child attains the limiting age under the bullets above. The time limit for written proof of incapacity and dependency is 30 days following the original eligibility date for a new or re-enrolling Employee. The Plan may require, at reasonable intervals, subsequent proof satisfactory to the Plan during the next two years after such date. After such two year period, the Plan may require such proof, but not more often than once each year.

"Dependent" does not include any person who is a member of the armed forces of any Country or who is a resident of a Country outside the United States.

The Plan reserves the right to require documentation, satisfactory to the Plan Administrator, which establishes a Dependent relationship.

"Detoxification"
"Detoxification" shall mean the process whereby an alcohol-intoxicated person or person experiencing the symptoms of Substance Abuse is assisted, in a facility licensed by the Department of Health, through the period of time necessary to eliminate, by metabolic or other means, the intoxicating alcohol, alcohol dependency factors or alcohol in combination with drugs as determined by a licensed Physician, while keeping the physiological risk to the patient at a minimum.

"Diagnosis"
"Diagnosis" shall mean the act or process of identifying or determining the nature and cause of a Disease or Injury through evaluation of patient history, examination, and review of laboratory data.

"Diagnostic Service"
"Diagnostic Service" shall mean a test or procedure performed for specified symptoms to detect or to monitor a Disease or condition. It must be ordered by a Physician or other professional Provider.

"Disease"
"Disease" shall mean any disorder which does not arise out of, which is not caused or contributed to by, and which is not a consequence of, any employment or occupation for compensation or profit; however, if evidence satisfactory to the Plan is furnished showing that the individual concerned is covered as an employee under any worker's compensation law, occupational disease law or any other legislation of similar purpose, or under the maritime doctrine of maintenance, wages, and cure, but that the disorder involved is one not covered under the applicable law or doctrine, then such disorder shall, for the purposes of the Plan, be regarded as a Sickness, Illness or Disease.

"Drug"
"Drug" shall mean insulin and prescription legend drugs. A prescription legend drug is a Federal legend drug (any medicinal substance which bears the legend: "Caution: Federal law prohibits dispensing without a prescription") or a State restricted drug (any medicinal substance which may be dispensed only by prescription, according to State law) and which, in either case, is legally obtained from a licensed drug dispenser only upon a prescription of a currently licensed Physician.

"Durable Medical Equipment"
"Durable Medical Equipment" shall mean equipment which:

1. Can withstand repeated use;
2. Is primarily and customarily used to serve a medical purpose;
3. Generally is not useful to a person in the absence of an Illness or Injury; and
4. Is appropriate for use in the home.

"Emergency"
"Emergency" shall mean a situation where necessary treatment is required as the result of a sudden and severe medical event or acute condition. An Emergency includes poisoning, shock, and hemorrhage. Other Emergencies and acute conditions may be considered on receipt of proof, satisfactory to the Plan, that an Emergency did exist. The Plan may, at its own discretion, request satisfactory proof that an Emergency or acute condition did exist.

"Emergency Medical Condition"
"Emergency Medical Condition" shall mean a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act (42 U.S.C. 1395dd(e)(1)(A)). In that

provision of the Social Security Act, clause (i) refers to placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; clause (ii) refers to serious impairment to bodily functions; and clause (iii) refers to serious dysfunction of any bodily organ or part.

"Emergency Services"
"Emergency Services" shall mean, with respect to an Emergency Medical Condition:

1. A medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition; and
2. Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd) to stabilize the patient.

"Employee"
"Employee" shall mean the classes of Employees who are eligible for coverage under the Plan as set forth in the Eligibility for Coverage section of this Summary Plan Description and the Plan's Eligibility Appendix. Contact the Plan Administrator for more information or to obtain a copy of the Plan's Eligibility Appendix.

"ERISA"
"ERISA" shall mean the Employee Retirement Income Security Act of 1974, as amended.

"Essential Health Benefits"
"Essential Health Benefits" shall mean, under section 1302(b) of the Patient Protection and Affordable Care Act, those health benefits to include at least the following general categories and the items and services covered within the categories: ambulatory patient services; Emergency Services; hospitalization; maternity and newborn care; mental health and substance abuse disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

"Experimental" and/or "Investigational"
"Experimental" and/or "Investigational" ("Experimental") shall mean services or treatments that are not widely used or accepted by most practitioners or lack credible evidence to support positive short or long-term outcomes from those services or treatments; these services are not included under or as Medicare reimbursable procedures, and include services, supplies, care, procedures, treatments or courses of treatment which:

1. Do not constitute accepted medical practice under the standards of the case and by the standards of a reasonable segment of the medical community or government oversight agencies at the time rendered; or
2. Are rendered on a research basis as determined by the United States Food and Drug Administration and the AMA's Council on Medical Specialty Societies.

All phases of clinical trials shall be considered Experimental.

A drug, device, or medical treatment or procedure is Experimental:

1. If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished;
2. If reliable evidence shows that the drug, device or medical treatment or procedure is the subject of ongoing Phase I, II, or III clinical trials or under study to determine its:
    a) maximum tolerated dose;
    b) toxicity;
    c) safety;
    d) efficacy; and
    e) efficacy as compared with the standard means of treatment or diagnosis; or

3. if reliable evidence shows that the consensus among experts regarding the drug, device, or medical treatment or procedure is that further studies or clinical trials are necessary to determine its:
    a) maximum tolerated dose;
    b) toxicity;
    c) safety;
    d) efficacy; and
    e) efficacy as compared with the standard means of treatment or diagnosis.

Reliable evidence shall mean:

1. Only published reports and articles in the authoritative medical and scientific literature;
2. The written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, or medical treatment or procedure; or
3. The written informed consent used by the treating facility or by another facility studying substantially the same drug, device, or medical treatment or procedure.

Notwithstanding the above, a prescription drug for a treatment that has been approved by the FDA but is used as a non-approved treatment shall not be considered Experimental/Investigational for purposes of this Plan and shall be afforded coverage to the same extent as any other prescription drug; provided that the drug is recognized by one of the following as being Medically Necessary for the specific treatment for which it has been prescribed:

1. The American Medical Association Drug Evaluations;
2. The American Hospital Formulary Service Drug Information;
3. The United States Pharmacopeia Drug Information; or
4. In the treatment of cancer, the National Comprehensive Cancer Network's Drugs and Biologics Compendium or Thomson Micromedex DRUGDEX.

The Plan Administrator retains maximum legal authority and discretion to determine what is Experimental.

"Family Unit"
"Family Unit" shall mean the Employee, his or her spouse and Children.

"Final Internal Adverse Benefit Determination"
"Final Internal Adverse Benefit Determination" shall mean an Adverse Benefit Determination that has been upheld by the Plan at the conclusion of the internal claims and appeals process, or an Adverse Benefit Determination with respect to which the internal claims and appeals process has been deemed exhausted.

"FMLA"
"FMLA" shall mean the Family and Medical Leave Act of 1993, as amended.

"FMLA Leave"
"FMLA Leave" shall mean a leave of absence, which the Company is required to extend to an Employee under the provisions of the FMLA.

"Genetic Testing"
"Genetic Testing" shall mean medical tests used to identify changes in chromosomes, genes or proteins.

"GINA"
"GINA" shall mean the Genetic Information Nondiscrimination Act of 2008 (Public Law No. 110-233), which prohibits group health plans, issuers of individual health care policies, and employers from discriminating on the basis of genetic information.

"Health Breach Notification Rule"
"Health Breach Notification Rule" shall mean 16 CFR Part 318.

"HIPAA"
"HIPAA" shall mean the Health Insurance Portability and Accountability Act of 1996, as amended.

"Home Health Care"
"Home Health Care" shall mean the continual care and treatment of an individual if:

1. The institutionalization of the individual would otherwise have been required if home health care was not provided;
2. The treatment plan covering the home health care service is established and approved in writing by the attending Physician; and
3. The home health care is the result of an Illness or Injury.

"Home Health Care Agency"
"Home Health Care Agency" shall mean an agency or organization which provides a program of home health care and which:

1. Is approved as a Home Health Agency under Medicare;
2. Is established and operated in accordance with the applicable laws in the jurisdiction in which it is located and, where licensing is required, has been licensed and approved by the regulatory authority having the responsibility for licensing; or
3. Meets all of the following requirements:
    a. It is an agency which holds itself forth to the public as having the primary purpose of providing a home health care delivery system bringing supportive services to the home;
    b. It has a full-time administrator;
    c. It maintains written records of services provided to the patient;
    d. Its staff includes at least one registered nurse (R.N.) or it has nursing care by a registered nurse (R.N.) available; and
    e. Its employees are bonded and it provides malpractice insurance.

"Hospital"
"Hospital" shall mean an Institution that meets all of the following requirements:

1. It provides medical and Surgical facilities for the treatment and care of Injured or Sick persons on an Inpatient basis;
2. It is under the supervision of a staff of Physicians;
3. It provides 24-hour-a-day nursing service by registered nurses;
4. It is duly licensed as a hospital, except that this requirement will not apply in the case of a State tax-supported Institution;
5. It is not, other than incidentally, a place for rest, a place for the aged, a nursing home or a custodial or training-type Institution, or an Institution which is supported in whole or in part by a Federal government fund; and
6. It is accredited by the Joint Commission on Accreditation of Hospitals sponsored by the AMA and the AHA.

The requirement of surgical facilities shall not apply to a Hospital specializing in the care and treatment of mentally ill patients, provided such Institution is accredited as such a facility by the Joint Commission on Accreditation of Hospitals sponsored by the AMA and the AHA.

"**Hospital**" shall also have the same meaning, where appropriate in context, set forth in the definition of "Ambulatory Surgical Center."

"Hours of Service"
"Hours of Service" means each hour for which the Employee is paid or entitled to payment for performance of services for the Employer AND any hour for which the employee is paid or entitled to payment by the Employer for

a period of time during which no duties are performed due to any of the following, consistent with 29 C.F.R. 2530.200b-2(a)(i):

1. Vacation
2. Holiday
3. Illness or incapacity
4. Layoff
5. Jury duty
6. Military duty or leave of absence.

"Illness"
"Illness" shall have the meaning set forth in the definition of "Disease."

"Impregnation and Infertility Treatment"
"Impregnation and Infertility Treatment" shall mean artificial insemination, fertility drugs, G.I.F.T. (Gamete Intrafallopian Transfer), impotency drugs such as Viagra™, in-vitro fertilization, sterilization and/or reversal of a sterilization operation, surrogate mother, donor eggs, or any type of artificial impregnation procedure, whether or not such procedure is successful.

"Incurred"
"Incurred" shall mean that a covered expense is Incurred on the date the service is rendered or the supply is obtained. With respect to a course of treatment or procedure which includes several steps or phases of treatment, covered expenses are Incurred for the various steps or phases as the services related to each step are rendered and not when services relating to the initial step or phase are rendered. More specifically, covered expenses for the entire procedure or course of treatment are not Incurred upon commencement of the first stage of the procedure or course of treatment.

"Initial Measurement Period"
For "Initial Measurement Period" please refer to the Plan's Eligibility Appendix.

"Injury"
"Injury" shall mean an Accidental Bodily Injury, which does not arise out of, which is not caused or contributed to by, and which is not a consequence of, any employment or occupation for compensation or profit.

"Inpatient"
"Inpatient" shall mean any person who, while confined to a Hospital, is assigned to a bed in any department of the Hospital other than its outpatient department and for whom a charge for Room and Board is made by the Hospital.

"Institution"
"Institution" shall mean a facility, operating within the scope of its license, whose purpose is to provide organized health care and treatment to individuals, such as a Hospital, Ambulatory Surgical Center, Psychiatric Hospital, community mental health center, residential treatment facility, psychiatric treatment facility, Substance Abuse Treatment Center, alternative birthing center, Home Health Care Center, or any other such facility that the Plan approves.

"Intensive Care Unit"
"Intensive Care Unit" shall have the same meaning set forth in the definition of "Cardiac Care Unit."

"Late Enrollee"
"Late Enrollee" shall mean a Participant who enrolls in the Plan other than:

1. On the earliest date on which coverage can become effective for the individual under the terms of the Plan; or
2. Through special enrollment.

"Leave of Absence"
"Leave of Absence" shall mean a leave of absence of an Employee that has been approved by his or her Participating Employer, as provided for in the Participating Employer's rules, policies, procedures and practices.

"Mastectomy"
"Mastectomy" shall mean the surgical removal of all or part of a breast.

"Maximum Amount" or **"Maximum Allowable Charge"**
"Maximum Amount" and/or "Maximum Allowable Charge" shall mean the benefit payable for a specific coverage item or benefit under the Plan. Maximum Allowable Charge(s) shall be calculated by the Plan Administrator taking into account and after having analyzed at least one of the following:

- The Usual and Customary amount;
- The allowable charge specified under the terms of the Plan;
- The negotiated rate established in a contractual arrangement with a Provider; or
- The actual billed charges for the covered services.

The Plan will reimburse the actual charge billed if it is less than the Usual and Customary amount. The Plan has the discretionary authority to decide if a charge is Usual and Customary and for a Medically Necessary and Reasonable service.

The **Maximum Allowable Charge** will not include any identifiable billing mistakes including, but not limited to, up-coding, duplicate charges, and charges for services not performed.

"Medical Child Support Order"
"Medical Child Support Order" shall mean any judgment, decree or order (including approval of a domestic relations settlement agreement) issued by a court of competent jurisdiction that:

1. Provides for child support with respect to a Participant's Child or directs the Participant to provide coverage under a health benefits plan pursuant to a State domestic relations law (including a community property law); or
2. Enforces a law relating to medical child support described in Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993 §13822) with respect to a group health plan.

"Medically Necessary"
"Medical Care Necessity", "Medically Necessary", "Medical Necessity" and similar language refers to health care services ordered by a Physician exercising prudent clinical judgment provided to a Plan Participant for the purposes of evaluation, diagnosis or treatment of that Plan Participant's Sickness or Injury. Such services, to be considered Medically Necessary, must be clinically appropriate in terms of type, frequency, extent, site and duration for the diagnosis or treatment of the Plan Participant's Sickness or Injury. The Medically Necessary setting and level of service is that setting and level of service which, considering the Plan Participant's medical symptoms and conditions, cannot be provided in a less intensive medical setting. Such services, to be considered Medically Necessary must be no more costly than alternative interventions, including no intervention and are at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the Plan Participant's Sickness or Injury without adversely affecting the Plan Participant's medical condition.

A) It must not be maintenance therapy or maintenance treatment.
B) Its purpose must be to restore health.
C) It must not be primarily custodial in nature.
D) It must not be a listed item or treatment not allowed for reimbursement by CMS (Medicare).
E) The Plan reserves the right to incorporate CMS (Medicare) guidelines in effect on the date of treatment as additional criteria for determination of Medical Necessity and/or an Allowable Expense.

For Hospital stays, this means that acute care as an Inpatient is necessary due to the kind of services the Participant is receiving or the severity of the Participant's condition and that safe and adequate care cannot be received as an

outpatient or in a less intensified medical setting. The mere fact that the service is furnished, prescribed or approved by a Physician does not mean that it is "Medically Necessary." In addition, the fact that certain services are excluded from coverage under this Plan because they are not "Medically Necessary" does not mean that any other services are deemed to be "Medically Necessary."

To be Medically Necessary, all of these criteria must be met. Merely because a Physician or Dentist recommends, approves, or orders certain care does not mean that it is Medically Necessary. The determination of whether a service, supply, or treatment is or is not Medically Necessary may include findings of the American Medical Association and the Plan Administrator's own medical advisors. The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary.

"Medical Record Review"
"Medical Record Review" is the process by which the Plan, based upon a medical record review and audit, determines that a different treatment or different quantity of a drug or supply was provided which is not supported in the billing, then the Plan Administrator may determine the **Maximum Allowable Charge** according to the medical record review and audit results.

"Medicare"
"Medicare" shall mean the program of health care for the aged established by Title XVIII of the Social Security Act of 1965, as amended.

"Mental Health Parity Act (MHPA) of 1996 and the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) Collectively, the Mental Health Parity Provisions in Part 7 of ERISA"
"The Mental Health Parity Provisions" shall mean in the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health or substance use disorder benefits, such plan or coverage shall ensure that:

1. The financial requirements applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the Plan (or coverage) and that there are no separate cost sharing requirements that are applicable only with respect to mental health or substance use disorder benefits. If these benefits are covered by the group health plan (or health insurance coverage is offered in connection with such a plan); and
2. The treatment limitations applicable to such mental health or substance use order benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the Plan (or coverage), and that there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits. If these benefits are covered by the group health plan (or health insurance coverage offered in connection with such a plan).

"Mental or Nervous Disorder"
"Mental or Nervous Disorder" shall mean any disease or condition, regardless of whether the cause is organic, that is classified as a Mental or Nervous Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services, is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association or other relevant State guideline or applicable sources.

"National Medical Support Notice" or "NMSN"
"National Medical Support Notice" or "NMSN" shall mean a notice that contains the following information:

1. Name of an issuing State agency;
2. Name and mailing address (if any) of an employee who is a Participant under the Plan;
3. Name and mailing address of one or more Alternate Recipients (i.e., the child or children of the Participant or the name and address of a substituted official or agency that has been substituted for the mailing address of the Alternate Recipients(s)); and
4. Identity of an underlying child support order.

"Network"
"Network" shall mean the medical provider network the Plan contracts to access discounted fees for service for Participants. The Network Provider will be identified on the Participants identification card.

"New Employee Stability Period"
"New Employee Stability Period" means the 12 Calendar Month period that begins on the first day of the Calendar Month following the Calendar Month that begins on or after the Employee's anniversary date.

"No-Fault Auto Insurance"
"No-Fault Auto Insurance" is the basic reparations provision of a law providing for payments without determining fault in connection with automobile accidents.

"Non-Occupational Injury"
"Non-occupational Injury" shall have the meaning set forth in the definition of "Injury."

"Non Network Fee Schedule (NNFS)"
"Non Network Fee Schedule (NNFS)" is a fee schedule used to re-price non-network claims.

"Ongoing Employee"
"Ongoing Employee" shall have the same meaning as Ongoing Employee set forth in the Summary Plan Description.

"Ongoing Employee Stability Period"
"Ongoing Employee Stability Period" means the 12 Calendar Month period that begins on the first day of each Plan Year following the end of the Plan's Standard Measurement Period.

"Open Enrollment Period"
"Open Enrollment Period" shall mean the period of time as determined by the Plan Sponsor each Plan Year.

"Other Plan"
"Other Plan" shall include, but is not limited to:

1. Any primary payer besides the Plan;
2. Any other group health plan;
3. Any other coverage or policy covering the Participant;
4. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
5. Any policy of insurance from any insurance company or guarantor of a responsible party;
6. Any policy of insurance from any insurance company or guarantor of a third party;
7. Worker's compensation or other liability insurance company; or
8. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

"Participant" / "Plan Participant"
"Participant" shall mean any Employee or Dependent who is eligible for benefits under the Plan.

"Patient Protection and Affordable Care Act (PPACA)"
The "Patient Protection and Affordable Care Act (PPACA)" means the health care reform law enacted in March 2010, Public Law 111-148; PPACA, together with the Health Care and Education Reconciliation Act, is commonly referred to as Affordable Care Act (ACA). (See "Affordable Care Act").

"Physician"
"Physician" shall mean a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dental Surgery (D.D.S.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Psychologist (Ph.D.), psychiatrist or midwife.

"Plan Year"
"Plan Year" shall mean a period commencing on the Effective Date or any anniversary of the adoption of this Plan and continuing until the next succeeding anniversary.

"Pre-admission Tests"
"Pre-admission Tests" shall mean those Diagnostic Services done prior to scheduled Surgery, provided that:

1. The tests are approved by both the Hospital and the Physician;
2. The tests are performed on an outpatient basis prior to Hospital admission; and
3. The tests are performed at the Hospital into which confinement is scheduled, or at a qualified facility designated by the Physician who will perform the Surgery.

"Preferred Provider Organization (PPO)"
"Preferred Provider Organization (PPO)" shall mean an organization that contracts with a network of providers from which the health plan Participant can choose. Participants do not need to select a primary care physician (PCP) and do not need referrals to see other providers in the network.

"Pregnancy"
"Pregnancy" shall mean carrying a child, resulting childbirth, miscarriage and non-elective abortion. The Plan considers Pregnancy as a Sickness for the purpose of determining benefits.

"Preventive Care"
"Preventive Care" shall mean certain Preventive Care services.

This Plan intends to comply with the Affordable Care Act's (ACA) requirement to offer in-Network coverage for certain preventive services without cost-sharing. To comply with the ACA, and in accordance with the recommendations and guidelines, the Plan will provide in-Network coverage for:

1. Evidence-based items or services rated A or B in the United States Preventive Services Task Force recommendations;
2. Recommendations of the Advisory Committee on Immunization Practices adopted by the Director of the Centers for Disease Control and Prevention;
3. Comprehensive guidelines for infants, Children, and adolescents supported by the Health Resources and Services Administration (HRSA); and
4. Comprehensive guidelines for women supported by the Health Resources and Services Administration (HRSA).

Copies of the recommendations and guidelines may be found here: http://www.uspreventiveservicestaskforce.org or at https://www.healthcare.gov/preventive-care-benefits/. For more information, you may contact the Plan Administrator / Employer.

"Prior to Effective Date" or "After Termination Date"
"Prior to Effective Date" or "After Termination Date" are dates occurring before a Participant gains eligibility from the Plan, or dates occurring after a Participant loses eligibility from the Plan, as well as charges incurred prior to the effective date of coverage under the Plan or after coverage is terminated, unless Extension of Benefits applies.

"Privacy Standards"
"Privacy Standards" shall mean the standards of the privacy of individually identifiable health information, as pursuant to HIPAA.

"Provider"
"Provider" shall mean a Physician, a licensed speech or occupational therapist, licensed professional physical therapist, physiotherapist, audiologist, speech language pathologist, licensed professional counselor, certified nurse practitioner, certified psychiatric/mental health clinical nurse, or other practitioner or facility defined or listed herein, or approved by the Plan Administrator.

"Psychiatric Hospital"
"Psychiatric Hospital" shall mean an Institution constituted, licensed, and operated as set forth in the laws that apply to Hospitals, which meets all of the following requirements:

1. It is primarily engaged in providing psychiatric services for the diagnosis and treatment of mentally ill persons either by, or under the supervision of, a Physician;
2. It maintains clinical records on all patients and keeps records as needed to determine the degree and intensity of treatment provided;
3. It is licensed as a psychiatric hospital;
4. It requires that every patient be under the care of a Physician; and
5. It provides 24-hour-a-day nursing service.

The term Psychiatric Hospital does not include an Institution, or that part of an Institution, used mainly for nursing care, rest care, convalescent care, care of the aged, Custodial Care or educational care.

"Qualified Medical Child Support Order" or "QMCSO"
"Qualified Medical Child Support Order" or "QMCSO" is a Medical Child Support Order that creates or recognizes the existence of an Alternate Recipient's right to, or assigns to an Alternate Recipient the right to, receive benefits for which a Participant or Eligible Dependent is entitled under this Plan.

"Qualifying Part-time Employee"
"Qualifying Part-time Employee" shall have the same meaning as Qualifying Part-time Employee set forth in the Summary Plan Description.

"Reasonable"
"Reasonable" and/or "Reasonableness" shall mean in the administrator's discretion, services or supplies, or fees for services or supplies which are necessary for the care and treatment of illness or injury not caused by the treating Provider's error or mistake. Determination that fee(s) or services are Reasonable will be made by the Plan Administrator, taking into consideration unusual circumstances or complications requiring additional time, skill and experience in connection with a particular service or supply; industry standards and practices as they relate to similar scenarios; and the cause of injury or illness necessitating the service(s) and/or charge(s).

This determination will consider, but will not be limited to evidence-based guidelines, and the findings and assessments of the following entities: (a) The National Medical Associations, Societies, and organizations; (b) The Centers for Medicare and Medicaid Services (CMS); and (c) The Food and Drug Administration. A finding of Provider negligence and/or malpractice is not required for service(s) and/or fee(s) to be considered not Reasonable.

To be Reasonable, service(s) and/or fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures. The Plan Administrator retains discretionary authority to determine whether service(s) and/or fee(s) are Reasonable based upon information presented to the Plan Administrator.

The Plan reserves for itself and parties acting on its behalf the right to review charges processed and/or paid by the Plan, to identify charge(s) and/or service(s) that are not Reasonable and therefore not eligible for payment by the Plan.

"Regular Full-time Employee"
"Regular Full-time Employee" means a common law employee who is regularly scheduled to work thirty (30) Hours of Service or more per week.

"Rehabilitation Hospital"
"Rehabilitation Hospital" shall mean an Institution which mainly provides therapeutic and restorative services to Sick or Injured people. It is recognized as such if:

1. It carries out its stated purpose under all relevant Federal, State and local laws;

2. It is accredited for its stated purpose by either the Joint Commission on Accreditation of Hospitals or the Commission on Accreditation for Rehabilitation Facilities; or
3. It is approved for its stated purpose by Medicare.

"Room and Board"
"Room and Board" shall mean a Hospital's charge for:

1. Room and linen service;
2. Dietary service, including meals, special diets and nourishment;
3. General nursing service; and
4. Other conditions of occupancy which are Medically Necessary.

"Scheduled benefit" or "Scheduled benefit amount" means a specified dollar amount that will be considered for reimbursement under the Plan for a particular type of medical care, service or supply provided. Scheduled benefits are based upon covered expenses not otherwise limited or excluded under the terms of the Plan. A partial listing of scheduled benefit amounts may be found in the section, "Summary of Benefits".

"Seasonal Employee"
"Seasonal Employee" means an Employee hired by the Employer into a position that is typically no longer in duration than 6 months and begins at the same time of the year each year.

"Security Standards"
"Security Standards" shall mean the final rule implementing HIPAA's Security Standards for the Protection of Electronic PHI, as amended.

"Service Waiting Period"
"Service Waiting Period" shall mean an interval of time during which the Employee is in the continuous, Active Employment of his or her Participating Employer.

"Sickness"
"Sickness" shall have the meaning set forth in the definition of "Disease."

"Significant Break in Coverage"
"Significant Break in Coverage" shall mean a period of 63 consecutive days during each of which an individual does not have any Creditable Coverage.

"Standard Measurement Period"
For "Standard Measurement Period" please refer to the Plan's Eligibility Appendix.

"Substance Abuse"
"Substance Abuse" shall mean any use of alcohol, any Drug (whether obtained legally or illegally), any narcotic, or any hallucinogenic or other illegal substance, which produces a pattern of pathological use, causing impairment in social or occupational functioning, or which produces physiological dependency evidenced by physical tolerance or withdrawal. It is the excessive use of a substance, especially alcohol or a drug. The DSM-IV definition is applied as follows:

A. A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a 12-month period:

    1. Recurrent substance use resulting in a failure to fulfill major role obligations at work, school or home (e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions or expulsions from school; neglect of children or household);
    2. Recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use);

3. Recurrent substance-related legal problems (e.g., arrests for substance-related disorderly conduct); or
4. Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with spouse about consequences of intoxication, physical fights);

B. The symptoms have never met the criteria for Substance Dependence for this class of substance.

"Substance Abuse Treatment Center"
"Substance Abuse Treatment Center" shall mean an Institution which provides a program for the treatment of Substance Abuse by means of a written treatment plan approved and monitored by a Physician. This Institution must be:

1. Affiliated with a Hospital under a contractual agreement with an established system for patient referral;
2. Accredited as such a facility by the Joint Commission on Accreditation of Hospitals; or
3. Licensed, certified or approved as an alcohol or Substance Abuse treatment program or center by a State agency having legal authority to do so.

Substance Dependence: Substance use history which includes the following: (1) substance abuse (see above); (2) continuation of use despite related problems; (3) development of tolerance (more of the drug is needed to achieve the same effect); and (4) withdrawal symptoms.

"Surgery"
"Surgery" shall mean any of the following:

1. The incision, excision, debridement or cauterization of any organ or part of the body, and the suturing of a wound;
2. The manipulative reduction of a fracture or dislocation or the manipulation of a joint including application of cast or traction;
3. The removal by endoscopic means of a stone or other foreign object from any part of the body or the diagnostic examination by endoscopic means of any part of the body;
4. The induction of artificial pneumothorax and the injection of sclerosing solutions;
5. Arthrodesis, paracentesis, arthrocentesis and all injections into the joints or bursa;
6. Obstetrical delivery and dilatation and curettage; or
7. Biopsy.

"Surgical Procedure"
"Surgical Procedure" shall have the same meaning set forth in the definition of "Surgery."

"Total Disability"
"Total Disability" shall mean an individual is determined as being disabled for Social Security purposes and provides such evidence to the Plan of the determination as the Plan Administrator may, in its sole discretion, require.

"Totally Disabled"
"Totally Disabled" shall have the same meaning set forth in the definition of "Total Disability."

"Uniformed Services"
"Uniformed Services" shall mean the Armed Forces, the Army National Guard and the Air National Guard, when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President of the United States in time of war or Emergency.

"USERRA"
"USERRA" shall mean the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA").

"Usual and Customary"
"Usual and Customary" (U&C) shall mean covered expenses which are identified by the Plan Administrator, taking into consideration the fee(s) which the Provider most frequently charges (or accepts for) the majority of patients for the service or supply, the cost to the Provider for providing the services, the prevailing range of fees charged in the same "area" by Providers of similar training and experience for the service or supply, and the Medicare reimbursement rates. The term(s) "same geographic locale" and/or "area" shall be defined as a metropolitan area, county, or such greater area as is necessary to obtain a representative cross-section of Providers, persons or organizations rendering such treatment, services, or supplies for which a specific charge is made. To be Usual and Customary, fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures.

The term "Usual" refers to the amount of a charge made or accepted for medical services, care, or supplies, to the extent that the charge does not exceed the common level of charges made by other medical professionals with similar credentials, or health care facilities, pharmacies, or equipment suppliers of similar standing, which are located in the same geographic locale in which the charge is incurred.

The term "Customary" refers to the form and substance of a service, supply, or treatment provided in accordance with generally accepted standards of medical practice to one individual, which is appropriate for the care or treatment of the same sex, comparable age and who receive such services or supplies within the same geographic locale.

The term "Usual and Customary" does not necessarily mean the actual charge made nor the specific service or supply furnished to a Plan Participant by a Provider of services or supplies, such as a physician, therapist, nurse, hospital, or pharmacist. The Plan Administrator will determine what the Usual and Customary charge is, for any procedure, service, or supply, and whether a specific procedure, service or supply is Usual and Customary.

Usual and Customary charges may, at the Plan Administrator's discretion, alternatively be determined and established by the Plan using normative data such as, but not limited to, Medicare cost to charge ratios, average wholesale price (AWP) for prescriptions and/or manufacturer's retail pricing (MRP) for supplies and devices.

All other defined terms in this Plan Document shall have the meanings specified in the Plan Document where they appear.

ARTICLE V
ELIGIBILITY FOR COVERAGE

5.01 Eligibility for Individual Coverage

The following classes of Employees will be eligible for coverage under the Plan:

1. **New Hires** -
   a. Regular Full-time Employees: Employees designated by the Employer as Regular Full-time Employees. Coverage for Regular Full-time Employees, if properly elected, will be effective immediately upon completion of a Service Waiting Period of 90 days.
   b. Qualifying Part-time Employee: Any other Employees, including but not limited to Seasonal Employees, who are not Regular Full-time Employees to the extent that such Employees average 30 hours of service per week over the employee's applicable Initial Measurement Period (as defined in the Plan Eligibility Appendix adopted by the Employer). Coverage for such Employees, if properly elected, will be effective on the first day of the Qualifying Part-time Employee's New Employee Stability Period (as defined by the Plan). A Qualifying Part-time Employee will remain eligible throughout the New Employee Stability Period to the extent that the employee remains employed, subject to the Plan's Break in Service (as defined by the Plan) rules.

      Note: if there is a gap between the end of the Qualifying Part-time Employee's New Employee Stability Period and the start of the Qualifying Part-time Employee's first Ongoing Employee Stability Period (see below), the Qualifying Part-time Employee will remain eligible under the Plan until the day preceding the start of the Ongoing Employee Stability Period to the extent the employee remains employed, subject to the Plan's Break in Service rules.

      If a Qualifying Part-time Employee transfers to a Regular Full-time Employee position prior to the start of the Qualifying Part-time Employee's New Employee Stability Period, the Employee will become eligible for coverage. If elected, coverage for such new Regular Full-time Employee will become eligible immediately upon completion of a Service Waiting Period of 90 days.

2. **"Ongoing" Employees** - Once an Employee has completed the Plan's Standard Measurement Period, eligibility will be based solely on the Employee's Hours of Service during the Plan's Standard Measurement Period. Any Employee who averages 30 Hours of Service per week during the Plan's Standard Measurement Period ("Ongoing Employees") will be eligible for coverage under the Plan during the Plan's next Ongoing Employee Stability Period to the extent that the Ongoing Employee remains employed, subject to the Plan's Break in Service rules. Such coverage, if elected, will be effective on the first day of the Plan's Ongoing Employee Stability Period.

Whether an Employee averages 30 Hours of Service per week will be determined in accordance with policies and procedures adopted by the Plan Administrator.

Impact of Breaks In Service

Any Employee who resumes Hours of Service following a Break in Service (as defined in the Plan Eligibility Appendix) will be treated as a New Hire and eligibility for coverage under the Plan upon return will be determined in accordance with the New Hire rules above. If, however, the Employee experiences a period without any Hours of Service, and resumes Hours of Service without experiencing a Break in Service, the Employee will be treated as a continuous employee. A continuous employee resuming Hours of Service after a period with no Hours of Service that does not constitute a Break in Service will be eligible for coverage under the Plan upon return if they were enrolled in coverage prior to the start of the period with No Hours of Service. Such coverage will be effective on the first day of the month that coincides with or follows the date you resume Hours of Service.

If you wish to review a copy of the Plan's Eligibility Appendix, please contact the Plan Administrator.

5.02 Eligibility Dates for Dependent Coverage

Each Employee will become eligible for coverage under this Plan for his or her Dependents on the latest of the following dates:

1. His or her date of eligibility for coverage for himself or herself under the Plan;
2. The date coverage for his or her Dependents first becomes available under any amendment to the Plan, if such coverage was not provided under the Plan on the Effective Date of the Plan; and
3. The first date upon which he or she acquires a Dependent.

In no event will any Dependent Child be covered as a Dependent of more than one Employee who is covered under the Plan.

Any reference in this Plan to an Employee's Dependent being covered means that such Employee is covered for Dependent Coverage.

5.03 Effective Dates of Coverage; Conditions

The coverage for which an individual is eligible under this Plan will become effective on the date specified below, subject to the conditions of this section.

1. Enrollment Form. Coverage for an Employee or his or her Dependents must be requested by the Employee on a form furnished by the Plan Administrator and will become effective on the date such Employee or Dependents are eligible, provided the Employee has enrolled for such coverage on a form satisfactory to the Plan Administrator within the 31-day period immediately following the date of eligibility.

2. Birth of Dependent Child. If a Dependent Child is born after the date the Employee's coverage for himself or herself under the Plan becomes effective and the Employee has coverage under this Plan for his or her Dependents, coverage shall take effect from and after the moment of birth, to the extent of the benefits provided herein, and any limitations of this Plan with respect to congenital defects shall not apply to such Child. Such coverage shall continue for the 31-day period commencing on the date of birth. In order to continue such coverage after the 31st day, prior to the end of the 31-day period, the Employee must make written application to the Plan for such Child and agree to make any required contribution.

   If the Employee does not have coverage under this Plan for any Dependents at the date of such Child's birth, then coverage for such Child shall be available only if, during the first 31 days following the date of birth, the Employee makes written application to the Plan for such Child and agrees to make any required contribution. In that event, coverage will be effective as of the moment of birth, to the extent of the benefits provided herein, and any limitations of this Plan with respect to congenital defects shall not apply to such Child.

3. Newly Acquired Dependents. If an Employee acquires a Dependent while the Employee is eligible for coverage for Dependents, coverage for the newly acquired Dependent shall be effective on the date the Dependent becomes eligible, provided application is made to the Plan within 31 days of the date of eligibility and any required contributions are made.

4. Requirement for Employee Coverage. No coverage for Dependents of an Employee will become effective unless the Employee is, or simultaneously becomes, eligible for coverage for himself or herself under the Plan.

5. Coverage as Both Employee and Dependent. No person may be simultaneously covered under this Plan as both an Employee and a Dependent.

6. Medicaid Coverage. An individual's eligibility for any State Medicaid benefits will not be taken into account by the Plan in determining that individual's eligibility under the Plan.

7. FMLA Leave. Regardless of any requirements set forth in the Plan, the Plan shall at all times comply with FMLA.

5.04 Special and Open Enrollment

The Plan provides special enrollment periods that allow Employee's to enroll in the Plan, even if they declined enrollment during an initial or subsequent eligibility period.

5.04A Loss of Other Coverage

If an Employee declined enrollment for himself or herself or his or her Dependents (including his or her spouse) because of other health coverage, he or she may enroll for coverage for himself or herself and/or his or her Dependents if the other health coverage is lost. The Employee must make written application for special enrollment within 30 days of the date the other health coverage was lost. For example, if the Employee loses his or her other health coverage on September 15, he or she must notify the Plan Administrator and apply for coverage by close of business on October 15.

The following conditions apply to any eligible Employee and Dependents*:*

An Employee may enroll during this special enrollment period:

1. If the Employee is eligible for coverage under the terms of this Plan*;*
2. The Employee is not currently enrolled under the Plan;
3. When enrollment was previously offered, the Employee declined because of coverage under another group health plan or health insurance coverage. The Employee must have provided a written statement that other health coverage was the reason for declining enrollment under this Plan*;* and
4. If the other coverage was terminated due to loss of eligibility for the coverage (including due to legal separation, divorce, death, termination of employment, or reduction in the number of hours), or because employer contributions for the coverage were terminated.

The Employee is not eligible for this special enrollment right if:

1. The other coverage was COBRA continuation coverage and the Employee did not exhaust the maximum time available to him or her for that COBRA coverage; or
2. The other coverage was lost due to non-payment of requisite contribution / premium or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the other plan).

If the conditions for special enrollment are satisfied, coverage for the Employee and/or his or her Dependent(s) will be effective at 12:01 A.M. on the first day of the first calendar month beginning after the date the written request is received by the Plan.

5.04B New Dependent

If an Employee acquires a new Dependent as a result of marriage, birth, adoption, or placement for adoption, he or she may be able to enroll himself or herself and his or her Dependents during a special enrollment period. The Employee must make written application for special enrollment no later than 30 days after he or she acquires the new Dependent. For example, if the Employee is married on September 15, he or she must notify the Plan Administrator and apply for coverage by close of business on October 15.

The following conditions apply to any eligible Employee and Dependents*:*

An Employee may enroll himself or herself and/or his or her eligible Dependents during this special enrollment period if:

1. The Employee is eligible for coverage under the terms of this Plan; and
2. The Employee has acquired a new Dependent through marriage, birth, adoption, or placement for adoption.

If the conditions for special enrollment are satisfied, coverage for the Employee and his or her Dependent(s) will be effective at 12:01 A.M.:

1. For a marriage, on the date of the marriage;
2. For a birth, on the date of birth; or
3. For an adoption or placement for adoption, on the date of the adoption or placement for adoption.

5.04C Additional Special Enrollment Rights

Employees and Dependents who are eligible but not enrolled are entitled to enroll under the following circumstances:

1. The Employee's or Dependent's Medicaid or State Child Health Insurance Plan (i.e. CHIP) coverage has terminated as a result of loss of eligibility and the Employee requests coverage under the Plan within 60 days after the termination; or
2. The Employee or Dependent become eligible for a contribution / premium assistance subsidy under Medicaid or a State Child Health Insurance Plan (i.e. CHIP), and the Employee requests coverage under the Plan within 60 days after eligibility is determined.

5.04D Open Enrollment

Participants may enroll for coverage during Open Enrollment Periods. Coverage for Participants enrolling during an Open Enrollment Period will become effective on January 1st, unless the Employee has not satisfied the Service Waiting Period, in which event coverage for the Employee and his or her Dependents will become effective on the day following completion of the Service Waiting Period.

"Open Enrollment Period" shall mean the period of time as determined by the Plan Sponsor each Plan Year.

5.04E Effective Date of Coverage; Conditions

All conditions for effectiveness of coverage under the Plan, which are set forth in the section entitled "Effective Dates of Coverage; Conditions," will apply to Participants enrolling during a Special or Open Enrollment Period. Coverage for Participants enrolling during a Special Enrollment Period will become effective on the first day following the enrollment due to loss of coverage or marriage, and on the date of birth, adoption or placement for adoption in the case of such events.

5.05 Qualified Medical Child Support Orders

The Plan Administrator shall enroll for immediate coverage under this Plan any Alternate Recipient who is the subject of a Medical Child Support Order that is a "Qualified Medical Child Support Order" ("QMCSO") if such an individual is not already covered by the Plan as an Eligible Dependent, once the Plan Administrator has determined that such order meets the standards for qualification set forth below.

"Alternate Recipient" shall mean any Child of a Participant who is recognized under a Medical Child Support Order as having a right to enrollment under this Plan as the Participant's Eligible Dependent. For purposes of the benefits provided under this Plan, an Alternate Recipient shall be treated as an Eligible Dependent, but for purposes of the reporting and disclosure requirements under ERISA, an Alternate Recipient shall have the same status as a Participant.

"Medical Child Support Order" shall mean any judgment, decree or order (including approval of a domestic relations settlement agreement) issued by a court of competent jurisdiction that:

1. Provides for child support with respect to a Participant's Child or directs the Participant to provide coverage under a health benefits plan pursuant to a State domestic relations law (including a community property law); or
2. Enforces a law relating to medical child support described in Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993 §13822) with respect to a group health plan.

"National Medical Support Notice" or "NMSN" shall mean a notice that contains the following information:

1. Name of an issuing State agency;
2. Name and mailing address (if any) of an employee who is a Participant under the Plan;
3. Name and mailing address of one or more Alternate Recipients (i.e., the child or children of the Participant or the name and address of a substituted official or agency that has been substituted for the mailing address of the Alternate Recipients(s)); and
4. Identity of an underlying child support order.

"Qualified Medical Child Support Order" or "QMCSO" is a Medical Child Support Order that creates or recognizes the existence of an Alternate Recipient's right to, or assigns to an Alternate Recipient the right to, receive benefits for which a Participant or Eligible Dependent is entitled under this Plan. In order for such order to be a QMCSO, it must clearly specify the following:

1. The name and last known mailing address (if any) of the Participant and the name and mailing address of each such Alternate Recipient covered by the order;
2. A reasonable description of the type of coverage to be provided by the Plan to each Alternate Recipient, or the manner in which such type of coverage is to be determined;
3. The period of coverage to which the order pertains; and
4. The name of this Plan.

In addition, a National Medical Support Notice shall be deemed a QMCSO if it:

1. Contains the information set forth above in the definition of "National Medical Support Notice";

2. a. Identifies either the specific type of coverage or all available group health coverage. If the Employer receives an NMSN that does not designate either specific type(s) of coverage or all available coverage, the Employer and the Plan Administrator will assume that all are designated;

   b. Informs the Plan Administrator that, if a group health plan has multiple options and the participant is not enrolled, the issuing agency will make a selection after the NMSN is qualified, and, if the agency does not respond within 20 days, the child will be enrolled under the Plan's default option (if any); and

3. Specifies that the period of coverage may end for the Alternate Recipient(s) only when similarly situated dependents are no longer eligible for coverage under the terms of the Plan, or upon the occurrence of certain specified events.

However, such an order need not be recognized as "qualified" if it requires the Plan to provide any type or form of benefit, or any option, not otherwise provided to the Participants and Eligible Plan Participants without regard to this section, except to the extent necessary to meet the requirements of a State law relating to medical child support orders, as described in Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993 §13822).

Upon receiving a Medical Child Support Order, the Plan Administrator shall, as soon as administratively possible:

1. Notify the Participant and each Alternate Recipient covered by the Order (at the address included in the Order) in writing of the receipt of such Order and the Plan's procedures for determining whether the Order qualifies as a QMCSO; and

2. Make an administrative determination if the order is a QMCSO and notify the Participant and each affected Alternate Recipient of such determination.

Upon receiving a National Medical Support Notice, the Plan Administrator shall:

1. Notify the State agency issuing the notice with respect to the child whether coverage of the child is available under the terms of the Plan and, if so:

a. Whether the child is covered under the Plan; and
b. Either the effective date of the coverage or, if necessary, any steps to be taken by the custodial parent or by the official of a State or political subdivision to effectuate the coverage; and

2. Provide to the custodial parent (or any State official serving in a substitute capacity) a description of the coverage available and any forms or documents necessary to effectuate such coverage.

To give effect to this requirement, the Plan Administrator shall:

1. Establish reasonable, written procedures for determining the qualified status of a Medical Child Support Order or National Medical Support Notice; and

2. Permit any Alternate Recipient to designate a representative for receipt of copies of the notices that are sent to the Alternate Recipient with respect to the Order.

5.06 Secondary Coverage

Participants who are eligible for secondary coverage by any other health plan are encouraged to obtain such coverage. Failure to obtain secondary coverage may result in the Plan member incurring costs, which are not covered by the Plan and which would otherwise be covered by the secondary coverage. The Plan will not pay for any costs which would have been payable by such secondary coverage, except to the extent that such costs are payable in any event by the Plan.

A provider that accepts the payment from the Plan will be deemed to consent and agree that (i) such payment shall be for the full amount due for the provision of services and supplies to a Participant and (ii) it shall not "balance bill" a Participant for any amount billed but not paid by the Plan.

5.07 Acquired Companies

Eligible Employees of an acquired company who are Actively at Work and were covered under the prior plan of the acquired company will be eligible for the benefits under this Plan on the date of acquisition. Any waiting period previously satisfied under the prior health plan will be applied toward satisfaction of the Service Waiting Period of this Plan. In the event that an acquired company did not have a health plan, all eligible Employees will be eligible on the date of the acquisition.

5.08 "GINA"

"GINA" prohibits group health plans, issuers of individual health care policies, and employers from discriminating on the basis of genetic information.

The term "genetic information" means, with respect to any individual, information about:

1. Such individual's genetic tests;
2. The genetic tests of family members of such individual; and
3. The manifestation of a disease or disorder in family members of such individual.

The term "genetic information" includes participating in clinical research involving genetic services. Genetic tests would include analysis of human DNA, RNA, chromosomes, proteins, or metabolite that detect genotypes, mutations, or chromosomal changes. Genetic information is a form of Protected Health Information (PHI) as defined by and in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and is subject to applicable Privacy and Security Standards.

Family members as it relates to GINA include dependents, plus all relatives to the fourth degree, without regard to whether they are related by blood, marriage, or adoption. Underwriting as it relates to GINA includes any rules for determining eligibility, computing premiums or contributions, and applying preexisting conditions. Offering reduced premiums or other rewards for providing genetic information would be impermissible underwriting.

GINA will not prohibit a health care Provider who is treating an individual from requesting that the patient undergo genetic testing. The rules permit the Plan to obtain genetic test results and use them to make claims payment determinations when it is necessary to do so to determine whether the treatment provided to the patient was medically advisable and/or necessary.

The Plan may request, but not require, genetic testing in certain very limited circumstances involving research, so long as the results are not used for underwriting, and then only with written notice to the individual that participation is voluntary and will not affect eligibility for benefits, premiums or contributions. In addition, the Plan will notify and describe its activity to the Health and Human Services secretary of its activities falling within this exception.

While the Plan may collect genetic information after initial enrollment, it may not do so in connection with any annual renewal process where the collection of information affects subsequent enrollment. The Plan will not adjust premiums or increase group contributions based upon genetic information, request or require genetic testing or collect genetic information either prior to or in connection with enrollment or for underwriting purposes.

5.09 Effect of Section 125 Tax Regulations on This Plan

The Plan Administrator has chosen to administer this Plan in accordance with Section 125 regulations of the Internal Revenue Code. Per this regulation, by enrolling in this plan, the Participant agrees to pretax salary reduction put toward the cost of his or her benefits.

Coverage Elections: Per Section 125 regulations, Participants are generally allowed to enroll for or change Coverage only during each annual enrollment period. However, exceptions are allowed if the Plan Administrator agrees and the Participant enrolls for or changes coverage within 31 days of the date the Participant meets the criteria shown below. The change must be consistent with the event.

Change of Status: A change in status is defined as:

- Change in legal marital status due to marriage, death of a spouse, or divorce;
- Change in number of dependents due to birth, adoption, placement for adoption, or death of a dependent;
- Change in employment status of employee, spouse or dependent due to termination or start of employment, strike, lockout, beginning or end of unpaid leave of absence, including under the Family and Medical Leave Act (FMLA), or change in worksite;
- Changes in employment status of employee, spouse or dependent resulting in eligibility or ineligibility for coverage;
- Changes which cause a dependent to become eligible or ineligible for coverage; and
- Change in residence from the network coverage area.

Court Order: A change in Coverage due to and consistent with a court order of the Employee or other person to cover a Dependent.

Medicare or Medicaid Eligibility/Entitlement: The Employee, Spouse or Dependent cancels or reduces Coverage due to entitlement to Medicare or Medicaid, or enrolls or increases Coverage due to loss of Medicare or Medicaid eligibility. The Employee or Dependent must request to enroll or cancel Coverage within 60 days after the Employee or Dependent is terminated from, or determined to be eligible, for such assistance.

Children's Health Insurance Program (CHIP): Employees and Dependents who are eligible but not enrolled for Coverage may enroll if: 1) the Employee's or Dependent's Medicaid or CHIP coverage is terminated as a result of loss of eligibility; or 2) the Employee or Dependent becomes eligible for a subsidy under Medicaid or CHIP. The Employee or Dependent must request to enroll or cancel Coverage within 60 days after the Employee or Dependent is terminated from, or determined to be eligible, for such assistance.

Change in Cost of Coverage: If the cost of benefits increases or decreases during a benefit period, the Plan Administrator may, in accordance with plan terms, automatically change the Participant's elective contribution.

When the change in cost is significant, the Participant may either increase his or her contribution or elect less-costly coverage. When a significant overall reduction is made to the benefit option the Participant has elected, the Participant may elect another available benefit option. When a new benefit option is added, the Participant may change his or her election to the new benefit option.

Changes in Coverage of Spouse or Dependent Under Another Employer's Plan: The Participant may make a Coverage election change if the plan of the Participant's Spouse or Dependent: (a) incurs a change such as adding or deleting a benefit option; (b) allows election changes due to Special Enrollment, Change in Status, Court Order or Medicare or Medicaid Eligibility/Entitlement; or (c) this Plan and the other plan have different periods of Coverage or open enrollment periods.

Revocation Due to Reduction in Hours: The Participant may revoke coverage under this Plan if he or she experiences a change in employment status so that the Participant is reasonably expected to average less than 30 hours of service per week, even if such a change does not cause the Participant to be ineligible, and the revocation of the election of coverage corresponds to the intended enrollment of the Participant and his or her dependents in another plan that provides minimum essential coverage with an effective date no later than the first day of the second month following the date coverage under this Plan is revoked.

Revocation Due to Enrollment in a Qualified Health Plan: The Participant may revoke coverage under this Plan if he or she is eligible for a Special Enrollment Period in a Qualified Health Plan through a Marketplace or the Participant seeks to enroll in a Qualified Health Plan through a Marketplace during the Marketplace's annual open enrollment period and the revocation of the election of coverage corresponds to the intended enrollment of the Participant and his or her dependents in a Qualified Health Plan through a Marketplace for new coverage with an effective date no later then the day immediately following the last day of coverage under this Plan.

There may be additional situations that qualify for a special enrollment opportunity. Contact the Plan Administrator for additional details.

ARTICLE VI
TERMINATION OF COVERAGE

6.01 Termination Dates of Individual Coverage

The coverage of any Employee for himself or herself under this Plan will terminate on the earliest to occur of the following dates:

1. The date of termination of the Plan;
2. The date of the expiration of the last period for which the Employee has made a contribution, in the event of his or her failure to make, when due, any contribution for coverage for himself or herself to which he or she has agreed in writing;
3. The date of the month in which he or she ceases to be eligible for such coverage under the Plan;
4. The date and time of the month in which the termination of employment occurs; or
5. Immediately after an Employee or his or her Dependent submits, or has knowledge of the submission of, a fraudulent claim or any fraudulent information to the Plan, including enrollment information.

6.02 Termination Dates of Dependent Coverage

The coverage for any Dependents of any Employee who are covered under the Plan will terminate on the earliest to occur of the following dates:

1. The date of termination of the Plan;
2. Upon the discontinuance of coverage for Dependents under the Plan;
3. The date of termination of the Employee's coverage for himself or herself under the Plan;
4. The date of the expiration of the last period for which the Employee has made a contribution, in the event of his or her failure to make, when due, any contribution for coverage for Dependents to which he or she has agreed in writing;
5. In the case of a Child age 26 or older for whom coverage is being continued due to mental or physical inability to earn his or her own living, the earliest to occur of:
    a. Cessation of such inability;
    b. Failure to furnish any required proof of the uninterrupted continuance of such inability or to submit to any required examination; or
    c. Upon the Child's no longer being dependent on the Employee for his or her support;
6. The day immediately preceding the date such person ceases to be a Dependent, as defined herein, except for termination due to age in which case coverage shall end the date the Dependent Child reaches age 26; or
7. Immediately after an Employee or his or her Dependent submits, or has knowledge of the submission of, a fraudulent claim or any fraudulent information to the Plan, including enrollment information.

6.03 Certificates of Coverage

The Plan will provide, a Certificate of Coverage upon request, at any time while the individual is covered under a plan and up to 24 months after the individual loses coverage under the Plan.

6.04 Prohibition on Rescission

The Plan will not rescind coverage for Covered Persons. This provision does not apply to cases where the Covered Person has engaged in fraud or made an intentional misrepresentation of material fact and advance notice of rescission is made by the Plan.

ARTICLE VII
CONTINUATION OF COVERAGE

7.01 Employer Continuation Coverage

Coverage will be continued for eligible Participants should the following occur:

1. In the event of Total Disability, coverage will continue for 3 months following termination of Active Employment or as determined by company policy; or
2. In the event of a leave of absence which does not meet the requirements of FMLA Leave, coverage will continue to the end of the period for which the Participant has made any required contribution.

7.02 Continuation During FMLA Leave

Regardless of the established leave policies mentioned above, the Plan shall at all times comply with FMLA. During any leave taken under FMLA, the Employee will maintain coverage under this Plan on the same conditions as coverage would have been provided if the covered Employee had been continuously employed during the entire leave period.

The Family and Medical Leave Act is a Federal law that applies, generally, to employers with 50 or more Employees, and provides that an eligible Employee may elect to continue coverage under this Plan during a period of approved FMLA Leave at the same cost as if the leave had not been taken.

If provisions under the Plan change while an Employee is on FMLA Leave, the changes will be effective for him or her on the same date as they would have been had he or she not taken leave.

7.02A Eligible Employees

Employees are eligible for FMLA Leave if all of the following conditions are met:

1. The Employee has been employed with the Participating Employer for at least 12 months;
2. The Employee has been employed with the Participating Employer at least 1,250 hours during the 12 consecutive months prior to the request for FMLA Leave; and
3. The Employee is employed at a worksite that employs at least 50 employees within a 75-mile radius.

7.02B Qualifying Circumstances for FMLA Leave

Coverage under FMLA Leave is limited to a total of 12 workweeks during any 12-month period that follows:

1. The birth of, and to care for, a Son or Daughter;
2. The placement of a Child with the Employee for adoption or foster care;
3. The Employee's taking leave to care for his or her Spouse, Son or Daughter, or Parent who has a Serious Health Condition;
4. The Employee's taking leave due to a Serious Health Condition which makes him or her unable to perform the functions of his or her position; or,
5. A Qualifying Exigency arising out of the fact that a Spouse, Son, Daughter, or Parent of the Employee is a member of a regular or reserve component of the Armed Forces and is on (or has been notified of impending call to) covered active duty.

Coverage under FMLA Leave is limited to a total of 26 workweeks during any 12-month period for the following situations:

1. To care for a service member following a Serious Illness or Injury to that service member, when the Employee is that service member's Spouse, Son or Daughter, Parent, or Next of Kin; or
2. To care for a veteran who is undergoing medical treatment, recuperation, or therapy for a Serious Illness or Injury that occurred any time during the five years preceding the date of treatment, when the Employee is that veteran's Spouse, Son or Daughter, Parent, or Next of Kin.

This leave may be considered as a paid (accrued vacation time, personal leave or family or sick leave, as applicable) or unpaid leave. The Participating Employer has the right to require that all paid leave be used prior to providing any unpaid leave.

An Employee must continue to pay his or her portion of the Plan contribution, if any, during the FMLA Leave. Payment must be made within 30 days of the due date established by the Plan Administrator. If payment is not received, coverage will terminate on the last date for which the contribution was received in a timely manner.

7.02C Notice Requirements

An Employee must provide at least 30 days' notice to his or her Participating Employer prior to beginning any leave under FMLA. If the nature of the leave does not permit such notice, the Employee must provide notice of the leave as soon as possible. The Participating Employer has the right to require medical certification to support the Employee's request for leave due to a Serious Health Condition for the Employee or his or her eligible family members.

7.02D Length of Leave

During any one 12-month period, the maximum amount of FMLA Leave may not exceed 12 workweeks for most FMLA related situations. The maximum periods for an Employee who is the primary care giver of a service member with a Serious Illness or Injury that was Incurred in the line of active duty may take up to 26 weeks of FMLA Leave in a single 12-month period to care for that service member. The Participating Employer may use any of four methods for determining this 12-month period.

If the Employee and his or her Spouse are both employed by the Participating Employer, FMLA Leave may be limited to a combined period of 12 workweeks, for both Spouses, when FMLA Leave is due to:

1. The birth or placement for adoption or foster care of a Child; or
2. The need to care for a Parent who has a Serious Health Condition.

7.02E Termination of FMLA Leave

Coverage may end before the maximum 12-week (or 26-week) period under the following circumstances:

1. When the Employee informs his or her Participating Employer of his or her intent not to return from leave;
2. When the employment relationship would have terminated but for the leave (such as during a reduction in force);
3. When the Employee fails to return from the leave;
4. If any required Plan contribution is not paid within 30 days of its due date;
5. The Participating Employer and/or Plan Administrator is advised and/or determines that no FMLA Qualifying Circumstance occurred.

If an Employee does not return to work when coverage under FMLA Leave ends, he or she will be eligible for *COBRA* continuation of coverage at that time, in accordance with the parameters set forth by this Plan and applicable law.

7.02F Recovery of Plan Contributions

The Participating Employer has the right to recover the portion of the Plan contributions it paid to maintain coverage under the Plan during an unpaid FMLA Leave if an Employee does not return to work at the end of the leave. This right will not apply if failure to return is due to the continuation, recurrence or onset of a Serious Health Condition that entitles the Employee to FMLA Leave (in which case the Participating Employer may require medical certification) or other circumstances beyond the Employee's control.

7.02G Reinstatement of Coverage

The law requires that coverage be reinstated upon the Employee's return to work following an FMLA Leave whether or not the Employee maintained coverage under the Plan during the FMLA Leave.

On reinstatement, all provisions and limits of the Plan will apply as they would have applied if FMLA Leave had not been taken. The Service Waiting Period will be credited as if the Employee had been continually covered under the Plan.

7.02H Definitions
For this provision only, the following terms are defined as stated.

"Next of Kin"
"Next of Kin" shall mean the nearest blood relative to the service member.

"Parent"
"Parent" shall mean the Employee's biological parent or someone who has acted as his or her parent in place of his or her biological parent when he or she was a Son or Daughter.

"Qualifying Exigency"
"Qualifying Exigency" shall mean:

1. Short-notice deployment.

    a. To address any issue that arises from the fact that a covered military member is notified seven or less calendar days prior to the date of deployment of an impending call or order to active duty in support of a contingency operation; and
    b. Leave taken for this purpose can be used for a period of seven calendar days beginning on the date a covered military member is notified of an impending call or order to active duty in support of a contingency operation;

2. Military events and related activities.

    a. To attend any official ceremony, program, or event sponsored by the military that is related to the active duty or call to active duty status of a covered military member; and
    b. To attend family support or assistance programs and informational briefings sponsored or promoted by the military, military service organizations, or the American Red Cross that are related to the active duty or call to active duty status of a covered military member;

3. Childcare and school activities.

    a. To arrange for alternative childcare when the active duty or call to active duty status of a covered military member necessitates a change in the existing childcare arrangement for a biological, adopted, or foster Child, a stepchild, or a legal ward of a covered military member, or a Child for whom a covered military member stands in loco parentis, who is either under age 18, or age 18 or older and incapable of self-care because of a mental or physical disability at the time that FMLA Leave is to commence;
    b. To provide childcare on an urgent, immediate need basis (but not on a routine, regular, or everyday basis) when the need to provide such care arises from the active duty or call to active duty status of a covered military member for a biological, adopted, or foster Child, a stepchild, or a legal ward of a covered military member, or a Child for whom a covered military member stands in loco parentis, who is either under age 18, or age 18 or older and incapable of self-care because of a mental or physical disability at the time that FMLA Leave is to commence;
    c. To enroll in or transfer to a new school or daycare facility, a biological, adopted, or foster Child, a stepchild, or a legal ward of the covered military member, or a Child for whom the covered military member stands in loco parentis, who is either under age 18, or age 18 or older and incapable of self-care because of a mental or physical disability at the time that FMLA Leave is to commence, when enrollment or transfer is necessitated by the active duty or call to active duty status of a covered military member; and
    d. To attend meetings with staff at a school or a daycare facility, such as meetings with school officials regarding disciplinary measures, parent-teacher conferences, or meetings with school counselors, for a

biological, adopted, or foster Child, a stepchild, or a legal ward of the covered military member, or a Child for whom the covered military member stands in loco parentis, who is either under age 18, or age 18 or older and incapable of self-care because of a mental or physical disability at the time that FMLA Leave is to commence, when such meetings are necessary due to circumstances arising from the active duty or call to active duty status of a covered military member;

4. Financial and legal arrangements. To make or update financial or legal arrangements to address the covered military member's absence while on active duty or call to active duty status, such as preparing and executing financial and healthcare powers of attorney, transferring bank account signature authority, enrolling in the Defense Enrollment Eligibility Reporting System (DEERS), obtaining military identification cards, or preparing or updating a will or living trust; and

5. Counseling. To attend counseling provided by someone other than a health care Provider for oneself, for the covered military member, or for the biological, adopted, or foster Child, a stepchild, or a legal ward of the covered military member, or a Child for whom the covered military member stands in loco parentis, who is either under age 18, or age 18 or older and incapable of self-care because of a mental or physical disability at the time that FMLA Leave is to commence, provided that the need for counseling arises from the active duty or call to active duty status of a covered military member;

6. Post-deployment activities.

   a. To attend arrival ceremonies, reintegration briefings and events, and any other official ceremony or program sponsored by the military for a period of 90 days following the termination of the covered military member's active duty status; and
   b. To address issues that arise from the death of a covered military member while on active duty status, such as meeting and recovering the body of the covered military member and making funeral arrangements; and

7. Additional activities. To address other events which arise out of the covered military member's active duty or call to active duty status provided that the Participating Employer and Employee agree that such leave shall qualify as an exigency, and agree to both the timing and duration of such leave.

"Serious Health Condition"
"Serious Health Condition" shall mean an Illness, Injury, impairment, or physical or mental condition that involves:

1. Inpatient care in a Hospital, hospice, or residential medical facility; or
2. Continuing treatment by a health care Provider (a doctor of medicine or osteopathy who is authorized to practice medicine or Surgery, as appropriate, by the State in which the doctor practices, or any other person determined by the Secretary of Labor to be capable of providing health care services).

"Serious Illness or Injury"
"Serious Illness or Injury" shall mean an Illness or Injury Incurred in the line of duty that may render the service member medically unfit to perform his or her military duties.

"Son or Daughter"
"Son or Daughter" shall mean the Employee's biological child, adopted child, stepchild, foster child, a child placed in the Employee's legal custody, or a child for which the Employee is acting as the parent in place of the child's natural blood related parent.

"Spouse"
"Spouse" shall mean an Employee's husband or wife.

NOTE: For complete information regarding FMLA rights, contact the Participating Employer.

7.03 Continuation During USERRA

Participants who are absent from employment because they are in the Uniformed Services may elect to continue their coverage under this Plan for up to 24 months. If a Participant elected to continue coverage under USERRA before December 10, 2004, the maximum period for continuing coverage is 18 months. To continue coverage, Participants must comply with the terms of the Plan, including election during the Plan's annual enrollment period, and pay their contributions, if any. In addition, USERRA also requires that, regardless of whether a Participant elected to continue his or her coverage under the Plan, his or her coverage and his or her dependents' coverage be reinstated immediately upon his or her return to employment, so long as he or she meets certain requirements contained in USERRA. Participants should contact their participating employer for information concerning their eligibility for USERRA and any requirements of the Plan.

7.04 Continuation During COBRA – Introduction

The right to this form of continued coverage was created by a Federal law, under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"). COBRA Continuation Coverage can become available to Participants when they otherwise would lose their group health coverage. It also can become available to other members of the Participants family who are covered under the Plan when they otherwise would lose their group health coverage. The entire cost (plus a reasonable administration fee) must be paid by the person. Coverage will end in certain instances, including if the Participant or their covered dependents fail to make timely payment of contributions or premiums. Participants should check with their employer to see if COBRA applies to them and/or their covered dependents.

7.04A COBRA Continuation Coverage

"COBRA Continuation Coverage" is a continuation of Plan coverage when coverage otherwise would end because of a life event known as a "Qualifying Event." Life insurance, accidental death and dismemberment benefits and weekly income or long-term disability benefits (if a part of the employer's plan) are not considered for continuation under COBRA.

7.04B Qualifying Events

Specific Qualifying Events are listed below. After a Qualifying Event, COBRA Continuation Coverage must be offered to each person who is a "Qualified Plan Participant." The Employee, the Employee's spouse, and the Employee's dependent children could become Qualified Plan Participants if coverage under the Plan is lost because of the Qualifying Event.

A covered Employee (meaning an employee covered under the Plan) will become a Qualified Plan Participant if he or she loses his or her coverage under the Plan because either one of the following Qualifying Events happens:

1. The hours of employment are reduced; or
2. The employment ends for any reason **other than gross misconduct**.

The spouse of a covered Employee will become a Qualified Plan Participant if he or she loses his or her coverage under the Plan because any of the following Qualifying Events happens:

1. The spouse dies;
2. The spouse's hours of employment are reduced;
3. The spouse's employment ends for any reason other than his or her gross misconduct;
4. The spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
5. The spouse becomes divorced or legally separated from his or her spouse.

Dependent children will become Qualified Plan Participants if they lose coverage under the Plan because any of the following Qualifying Events happens:

1. The parent-covered Employee dies;
2. The parent-covered Employee's hours of employment are reduced;
3. The parent-covered Employee's employment ends for any reason other than his or her gross misconduct;
4. The parent-covered Employee becomes entitled to Medicare benefits (Part A, Part B, or both);

5. The parents become divorced or legally separated; or
6. The child stops being eligible for coverage under the Plan as a Dependent Child.

If a proceeding in bankruptcy is filed with respect to Gilster-Mary Lee Corporation, and that bankruptcy results in the loss of coverage of any retired employee, spouse, surviving spouse, and Dependent Children covered under the Plan, such member will become a Qualified Plan Participant with respect to the bankruptcy.

7.04C Employer Notice of Qualifying Events

When the Qualifying Event is the end of employment (for reasons other than gross misconduct), reduction of hours of employment, death of the covered Employee, or the covered Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the Employer must notify the Third Party Administrator of the Qualifying Event.

7.04D Employee Notice of Qualifying Events

Each covered Employee or Qualified Plan Participant is responsible for providing the Plan Administrator with the following notices, in writing, by U.S. First Class Mail:

1. Notice of the occurrence of a Qualifying Event that is a divorce or legal separation of a covered Employee (or former employee) from his or her spouse;
2. Notice of the occurrence of a Qualifying Event that is an individual's ceasing to be eligible as a Dependent Child under the terms of the Plan;
3. Notice of the occurrence of a second Qualifying Event after a Qualified Plan Participant has become entitled to COBRA Continuation Coverage with a maximum duration of 18 (or 29) months;
4. Notice that a Qualified Plan Participant entitled to receive Continuation Coverage with a maximum duration of 18 months has been determined by the Social Security Administration ("SSA") to be disabled at any time during the first 60 days of Continuation Coverage; and
5. Notice that a Qualified Plan Participant, with respect to whom a notice described above has been provided, has subsequently been determined by the SSA to no longer be disabled.

The Third Party Administrator is:

HealthSCOPE Benefits
P.O. Box 2459
Little Rock, AR 72203

A form of notice is available, free of charge, from the Third Party Administrator and must be used when providing the notice.

7.04E Deadline for providing the notice

For Qualifying Events described above, the notice must be furnished by the date that is 60 days after the latest of:

1. The date on which the relevant Qualifying Event occurs;
2. The date on which the Qualified Plan Participant loses (or would lose) coverage under the Plan as a result of the Qualifying Event; or
3. The date on which the Qualified Plan Participant is informed, through the furnishing of the Plan's SPD or the general notice, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Third Party Administrator.

For the disability determination described above, the notice must be furnished by the date that is 60 days after the latest of:

1. The date of the disability determination by the SSA;
2. The date on which a Qualifying Event occurs;
3. The date on which the Qualified Plan Participant loses (or would lose) coverage under the Plan as a result of the Qualifying Event; or

4. The date on which the Qualified Plan Participant is informed, through the furnishing of the Plan's SPD or the general notice, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Third Party Administrator.

In any event, this notice must be furnished before the end of the first 18 months of Continuation Coverage.

For a change in disability status described above, the notice must be furnished by the date that is 30 days after the later of:

1. The date of the final determination by the SSA that the Qualified Plan Participant is no longer disabled; or
2. The date on which the Qualified Plan Participant is informed, through the furnishing of the Plan's SPD or the general notice, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Third Party Administrator.

The notice must be postmarked by the deadline set forth above. If the notice is late, the opportunity to elect or extend COBRA Continuation Coverage is lost, and if the person is electing COBRA Continuation Coverage, his or her coverage under the Plan will terminate on the last date for which he or she is eligible under the terms of the Plan, or if the person is extending COBRA Continuation Coverage, such Coverage will end on the last day of the initial 18-month COBRA coverage period.

7.04F Who Can Provide the Notice

Any individual who is the covered Employee (or former employee), a Qualified Plan Participant with respect to the Qualifying Event, or any representative acting on behalf of the covered Employee (or former employee) or Qualified Plan Participant, may provide the notice, and the provision of notice by one individual shall satisfy any responsibility to provide notice on behalf of all related Qualified Plan Participants with respect to the Qualifying Event.

7.04G Required Contents of the Notice

The notice must contain the following information:

1. Name and address of the covered Employee or former employee;
2. Identification of the initial Qualifying Event and its date of occurrence, if the person is already receiving COBRA Continuation Coverage and wishes to extend the maximum coverage period;
3. A description of the Qualifying Event (for example, divorce, legal separation, cessation of dependent status, entitlement to Medicare by the covered Employee or former employee, death of the covered Employee or former employee, disability of a Qualified Plan Participant or loss of disability status);
4. In the case of a Qualifying Event that is divorce or legal separation, name(s) and address(es) of spouse and dependent child(ren) covered under the Plan, date of divorce or legal separation, and a copy of the decree of divorce or legal separation;
5. In the case of a Qualifying Event that is Medicare entitlement of the covered Employee or former employee, date of entitlement, and name(s) and address(es) of spouse and Dependent child(ren) covered under the Plan;
6. In the case of a Qualifying Event that is a Dependent Child's cessation of Dependent status under the Plan, name and address of the Child, reason the Child ceased to be an eligible Dependent (for example, attained limiting age, lost student status, married or other);
7. In the case of a Qualifying Event that is the death of the covered Employee or former employee, the date of death, and name(s) and address(es) of spouse and Dependent Child(ren) covered under the Plan;
8. In the case of a Qualifying Event that is disability of a Qualified Plan Participant, name and address of the disabled Qualified Plan Participant, name(s) and address(es) of other family members covered under the Plan, the date the disability began, the date of the SSA's determination, and a copy of the SSA's determination;
9. In the case of a Qualifying Event that is loss of disability status, name and address of the Qualified Plan Participant who is no longer disabled, name(s) and address(es) of other family members covered under the Plan, the date the disability ended and the date of the SSA's determination; and
10. A certification that the information is true and correct, a signature and date.

If a copy of the decree of divorce or legal separation or the SSA's determination cannot be provided by the deadline for providing the notice, complete and provide the notice, as instructed, by the deadline and submit the copy of the decree of divorce or legal separation or the SSA's determination within 30 days after the deadline. The notice will be timely if done so. However, no COBRA Continuation Coverage, or extension of such Coverage, will be available until the copy of the decree of divorce or legal separation or the SSA's determination is provided.

If the notice does not contain all of the required information, the Third Party Administrator may request additional information. If the individual fails to provide such information within the time period specified by the Third Party Administrator in the request, the Plan Administrator may reject the notice if it does not contain enough information for the Plan Administrator to identify the plan, the covered Employee (or former employee), the Qualified Plan Participants, the Qualifying Event or disability, and the date on which the Qualifying Event, if any, occurred.

7.04H Electing COBRA Continuation Coverage

Complete instructions on how to elect COBRA Continuation Coverage will be provided by the Third Party Administrator within 14 days **of receiving the notice of the Qualifying Event**. The individual then has 60 days in which to elect COBRA Continuation Coverage. The 60-day period is measured from the later of the date coverage terminates and the date of the notice containing the instructions. If COBRA Continuation Coverage is not elected in that 60-day period, then the right to elect it ceases.

Each Qualified Plan Participant will have an independent right to elect COBRA Continuation Coverage. Covered Employees may elect COBRA Continuation Coverage on behalf of their spouses, and parents may elect COBRA Continuation Coverage on behalf of their children.

In the event that the Plan Administrator determines that the individual is not entitled to COBRA Continuation Coverage, the Third Party Administrator will provide to the individual an explanation as to why he or she is not entitled to COBRA Continuation Coverage.

7.04I Duration of COBRA Continuation Coverage

COBRA Continuation Coverage will be available up to the maximum time period shown below. Generally, multiple Qualifying Events which may be combined under COBRA will not continue coverage for more than 36 months beyond the date of the original Qualifying Event. When the Qualifying Event is "entitlement to Medicare," the 36-month continuation period is measured from the date of the original Qualifying Event. For all other Qualifying Events, the continuation period is measured from the date of the Qualifying Event, not the date of loss of coverage.

When the Qualifying Event is the death of the covered Employee (or former employee), the covered Employee's (or former employee's) becoming entitled to Medicare benefits (under Part A, Part B, or both), a divorce or legal separation, or a Dependent Child's losing eligibility as a Dependent Child, COBRA Continuation Coverage lasts for up to a total of 36 months.

When the Qualifying Event is the end of employment or reduction of the covered Employee's hours of employment, and the covered Employee became entitled to Medicare benefits less than 18 months before the Qualifying Event, COBRA Continuation Coverage for Qualified Plan Participants other than the covered Employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered Employee becomes entitled to Medicare eight months before the date on which his or her employment terminates, COBRA Continuation Coverage for his or her spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the Qualifying Event (36 months minus 8 months).

Otherwise, when the Qualifying Event is the end of employment (for reasons other than gross misconduct) or reduction of the covered Employee's hours of employment, COBRA Continuation Coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA Continuation Coverage can be extended.

7.04J Disability Extension of COBRA Continuation Coverage

If an Employee or anyone in an Employee's family covered under the Plan is determined by the SSA to be disabled and the Employee notifies the Third Party Administrator as set forth above, the Employee and his or her entire

family may be entitled to receive up to an additional 11 months of COBRA Continuation Coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA Continuation Coverage and must last at least until the end of the 18-month period of COBRA Continuation Coverage. An extra fee will be charged for this extended COBRA Continuation Coverage.

7.04K Second Qualifying Event Extension of COBRA Continuation Coverage

If an Employee's family experiences another Qualifying Event while receiving 18 months of COBRA Continuation Coverage, the spouse and Dependent Children in the family can get up to 18 additional months of COBRA Continuation Coverage, for a maximum of 36 months, if notice of the second Qualifying Event properly is given to the Plan as set forth above. This extension may be available to the spouse and any Dependent Children receiving COBRA Continuation Coverage if the covered Employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the Dependent Child stops being eligible under the Plan as a Dependent Child, but only if the event would have caused the spouse or Dependent Child to lose coverage under the Plan had the first Qualifying Event not occurred.

7.04L Shorter Duration of COBRA Continuation Coverage

COBRA Continuation Coverage also may end before the end of the maximum period on the earliest of the following dates:

1. The date the employer ceases to provide a group health plan to any employee;
2. The date on which coverage ceases by reason of the Qualified Plan Participant's failure to make timely payment of any required contributions or premium;
3. The date that the Qualified Plan Participant first becomes, after the date of election, covered under any other group health plan (as an employee or otherwise), or entitled to either Medicare Part A or Part B (whichever comes first) except as stated under COBRA's special bankruptcy rules; or
4. The first day of the month that begins more than 30 days after the date of the SSA's determination that the Qualified Plan Participant is no longer disabled, but in no event before the end of the maximum coverage period that applied without taking into consideration the disability extension.

7.04M Contribution and/or Premium Requirements

Once COBRA Continuation Coverage is elected, the individual must pay for the cost of the initial period of coverage within 45 days. Payments then are due on the first day of each month to continue coverage for that month. If a payment is not received within 30 days of the due date, COBRA Continuation Coverage will be canceled and will not be reinstated.

7.05 Additional Information

Additional information about the Plan and COBRA Continuation Coverage is available from the Plan Administrator, who is:

Gilster-Mary Lee Corporation
Plan Administrator
1037 State Street
Chester, IL 62233
618-826-2361

For more information about a Participant's rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

7.06 Current Addresses

In order to protect the rights of the Employee's family, the Employee should keep the Plan Administrator (who is identified above) informed of any changes in the addresses of family members.

ARTICLE VIII
GENERAL LIMITATIONS AND EXCLUSIONS

This section applies to all benefits provided under any section of this Plan. This Plan does not cover any charge for care, supplies, treatment, and/or services:

Complications of Non-Covered Treatments. Care, services or treatment required as a result of complications from a treatment not covered under the Plan; unless specified as covered herein;

Custodial Care. That do not restore health, unless specifically mentioned otherwise;

Deductible Applicable. That are not payable due to the application of any specified Deductible provisions contained herein;

Error. That are required to treat injuries that are sustained or an illness that is contracted, including infections and complications, while the Plan Participant was under, and due to, the care of a Provider wherein such illness, injury, infection or complication is not reasonably expected to occur. This exclusion will apply to expenses directly or indirectly resulting from the circumstances of the course of treatment that, in the opinion of the Plan Administrator, in its sole discretion, unreasonably gave rise to the expense;

Excess. That are not payable under the Plan due to application of any Plan maximum or limit or because the charges are in excess of the Usual and Customary amount, or are for services not deemed to be Reasonable or Medically Necessary, based upon the Plan Administrator's determination as set forth by and within the terms of this document;

Experimental. That are Experimental or Investigational;

Government. That are expenses to the extent paid, or which the Participant is entitled to have paid or obtain without cost, in accordance with the laws or regulations of any government;

Illegal acts. For services and supplies incurred as a result of an Illness or Injury, caused by or contributed to by engaging in an illegal act, by committing or attempting to commit a crime or by participating in a riot or public disturbance;

Incurred by Other Persons. For expenses actually incurred by other persons;

Medical Necessity. That are not Medically Necessary;

Medicare. For benefits that are provided, or which would have been provided had the Participant enrolled, applied for, or maintained eligibility for such care and service benefits, under Title XVIII of the Federal Social Security Act of 1965 (Medicare), including any amendments thereto, or under any Federal law or regulation, except as provided in the sections entitled "Coordination of Benefits" and "Medicare;"

Negligence. For Injuries resulting from negligence, misfeasance, malfeasance, nonfeasance or malpractice on the part of any licensed Physician;

No Legal Obligation. That are provided to a Participant for which the Provider of a service customarily makes no direct charge, or for which the Participant is not legally obligated to pay, or for which no charges would be made in the absence of this coverage, including but not limited to fees, care, supplies, or services for which a person, company or any other entity except the Participant or this benefit plan, ***may be liable*** for necessitating the fees, care, supplies, or services;

Not Acceptable. That are not accepted as standard practice by the AMA, ADA, or the Food and Drug Administration;

Not Actually Rendered. That are not actually rendered;

Not Specifically Covered. That are not specifically covered under this Plan;

Occupational. For any condition, Illness, Injury or complication thereof arising out of or in the course of employment, including self-employment, or an activity for wage or profit where workers' compensation or another form of occupational injury medical coverage is available;

Participant Liability Waived. For charges in connection with a claim where the Participant does not meet his or her cost-sharing responsibility (i.e. copay, deductible or coinsurance). This exclusion applies regardless of whether the Provider charges or attempts to collect the Participant's cost-sharing responsibility.

Prior to Coverage. That are rendered or received prior to or after any period of coverage hereunder, except as specifically provided herein;

Prohibited by Law. To the extent that payment under this Plan is prohibited by law;

Provider Error. Required as a result of unreasonable provider error;

Subrogation, Reimbursement, and/or Third Party Responsibility. Of an Injury or Sickness not payable by virtue of the Plan's subrogation, reimbursement, and/or third party responsibility provisions; and

War. Incurred as a result of war or any act of war, whether declared or undeclared, or any act of aggression, when the Participant is a member of the armed forces of any Country, or during service by a Participant in the armed forces of any Country. This exclusion does not apply to any Participant who is not a member of the armed forces.

With respect to any Injury which is otherwise covered by the Plan, the Plan will not deny benefits otherwise provided for treatment of the Injury if the Injury results from an act of domestic violence or a medical condition.

ARTICLE IX
PLAN ADMINISTRATION

The Plan is administered by the Plan Administrator. The Plan Administrator has retained the services of the Third Party Administrator to provide certain claims processing and other technical services.

9.01 Plan Administrator

The Plan is administered by the Plan Administrator within the purview of ERISA, and in accordance with these provisions. An individual or entity may be appointed by the Plan Sponsor to be Plan Administrator and serve at the convenience of the Plan Sponsor. If the Plan Administrator resigns, dies, is otherwise unable to perform, is dissolved, or is removed from the position, the Plan Sponsor shall appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits (including the determination of what services, supplies, care and treatments are Experimental), to decide disputes which may arise relative to a Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator as to the facts related to any claim for benefits and the meaning and intent of any provision of the Plan, or its application to any claim, shall receive the maximum deference provided by law and will be final and binding on all interested parties. Benefits under this Plan will be paid only if the Plan Administrator decides, in its discretion, that the Participant is entitled to them.

The Plan Administrator has the discretionary authority to decide whether a charge is Usual and Reasonable. Benefits under this Plan shall be paid only if the Plan Administrator decides in its discretion that a Plan member is entitled to them.

9.02 Duties of the Plan Administrator

The duties of the Plan Administrator include the following:

1. To administer the Plan in accordance with its terms;
2. To determine all questions of eligibility, status and coverage under the Plan;
3. To interpret the Plan, including the authority to construe possible ambiguities, inconsistencies, omissions and disputed terms;
4. To make factual findings;
5. To decide disputes which may arise relative to a Participant's rights and/or availability of benefits;
6. To prescribe procedures for filing a claim for benefits, to review claim denials and appeals relating to them and to uphold or reverse such denials;
7. To keep and maintain the Plan documents and all other records pertaining to the Plan;
8. To appoint and supervise a third party administrator to pay claims;
9. To perform all necessary reporting as required by ERISA;
10. To establish and communicate procedures to determine whether a medical child support order is a QMCSO;
11. To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate; and
12. To perform each and every function necessary for or related to the Plan's administration.

9.03 Amending and Terminating the Plan

The Plan Sponsor expects to maintain this Plan indefinitely; however, as the settlor of the Plan, the Plan Sponsor, through its directors and officers, may, in its sole discretion, at any time, amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan or the Trust Agreement (if any). This includes amending the benefits under the Plan.

Any such amendment, suspension or termination shall be enacted, if the Plan Sponsor is a corporation, by resolution of the Plan Sponsor's directors and officers, which shall be acted upon as provided in the Plan Sponsor's Articles of

Incorporation or Bylaws, as applicable, and in accordance with applicable Federal and State law. Notice shall be provided as required by ERISA. In the event that the Plan Sponsor is a different type of entity, then such amendment, suspension or termination shall be taken and enacted in accordance with applicable Federal and State law and any applicable governing documents. In the event that the Plan Sponsor is a sole proprietorship, then such action shall be taken by the sole proprietor, in his or her own discretion.

If the Plan is terminated, the rights of the Participants are limited to expenses incurred before termination. All amendments to this Plan shall become effective as of a date established by the Plan Sponsor.

9.04 Final Authority of the Plan Document

The terms and provisions contained in this Plan Document and Summary Plan Description shall be final and binding upon all Participants. Contradictory benefit information received from any other source will not effect the terms of the Plan as set forth herein. Participants are advised to conclusively rely upon the benefit information provided in this Plan Document and Summary Plan Description only.

9.05 Summary of Material Reduction (SMR)

A Material Reduction generally means any modification that would be considered by the average Participant to be an important reduction in covered services or benefits. Examples include reductions in benefits or increases in Deductibles or copayments.

The Plan Administrator shall notify all eligible Employees of any plan amendment considered a Material Reduction in covered services or benefits provided by the Plan as soon as administratively feasible after its adoption, but no later than 60 days after the date of adoption of the reduction. Eligible Employees and beneficiaries must be furnished a summary of such reductions, and any changes so made shall be binding on each Participant. The 60 day period for furnishing a summary of Material Reduction does not apply to any Employee covered by the Plan who would reasonably expect to receive a summary through other means within the next 90 days.

Material Reduction disclosure provisions are subject to the requirements of ERISA and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and any related amendments.

9.06 Summary of Material Modification (SMM)

A Summary of Material Modifications reports changes in the information provided within the Summary Plan Description. Examples include a change to Deductibles, eligibility or the addition or deletion of coverage.

The Plan Administrator shall notify all covered Employees of any plan amendment considered a Summary of Material Modifications by the Plan as soon as administratively feasible after its adoption, but no later than within 210 days after the close of the Plan Year in which the changes became effective.

Note: The Affordable Care Act (ACA) requires that if a Plan's Material Modifications are not reflected in the Plan's most recent Summary of Benefits and Coverage (SBC) then the Plan must provide written notice to Participants at least 60 days before the effective date of the Material Modification.

9.07 Misuse of Identification Card

If an Employee or covered Dependent permits any person who is not a covered Participant of the Family Unit to use any identification card issued, the Plan Sponsor may give Employee written notice that his (and his family's) coverage will be terminated at the end of 31 days from the date written notice is given.

ARTICLE X
CLAIM PROCEDURES; PAYMENT OF CLAIMS

The procedures outlined below must be followed by Participants to obtain payment of health benefits under this Plan.

10.01 Health Claims

All claims and questions regarding health claims should be directed to the Third Party Administrator. The Plan Administrator shall be ultimately and finally responsible for adjudicating such claims and for providing full and fair review of the decision on such claims in accordance with the following provisions and with ERISA. Benefits under the Plan will be paid only if the Plan Administrator decides in its discretion that the Participant is entitled to them. The responsibility to process claims in accordance with the Plan Document may be delegated to the Third Party Administrator; provided, however, that the Third Party Administrator is not a fiduciary of the Plan and does not have the authority to make decisions involving the use of discretion.

Each Participant claiming benefits under the Plan shall be responsible for supplying, at such times and in such manner as the Plan Administrator in its sole discretion may require, written proof that the expenses were incurred or that the benefit is covered under the Plan. If the Plan Administrator in its sole discretion shall determine that the Participant has not incurred a covered expense or that the benefit is not covered under the Plan, or if the Participant shall fail to furnish such proof as is requested, no benefits shall be payable under the Plan.

A call from a Provider who wants to know if an individual is covered under the Plan, or if a certain procedure is covered by the Plan, prior to providing treatment is not a "claim," since an actual claim for benefits is not being filed with the Plan. These are simply requests for information, and **any response is not a guarantee of benefits, since payment of benefits is subject to all Plan provisions, limitations and exclusions**. Once treatment is rendered, a Clean Claim must be filed with the Plan (which will be a "Post-service Claim"). At that time, a determination will be made as to what benefits are payable under the Plan.

A Participant has the right to request a review of an Adverse Benefit Determination. If the claim is denied at the end of the appeal process, as described below, the Plan's final decision is known as a final Adverse Benefit Determination. If the Participant receives notice of a final Adverse Benefit Determination, or if the Plan does not follow the claims procedures properly, the Participant then has the right to request an independent external review. The external review procedures are described below.

The claims procedures are intended to provide a full and fair review. This means, among other things, that claims and appeals will be decided in a manner designed to ensure the independence and impartiality of the persons involved in making these decisions.

Benefits will be payable to a Plan Participant, or to a Provider that has accepted an assignment of benefits as consideration in full for services rendered.

According to Federal regulations which apply to the Plan, there are four types of claims: Pre-service (Urgent and Non-urgent), Concurrent Care and Post-service.

- Pre-service Claims. A "pre-service claim" is a claim for a benefit under the Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

  A "pre-service urgent care claim" is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the Participant or the Participant's ability to regain maximum function, or, in the opinion of a physician with knowledge of the Participant's medical condition, would subject the Participant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

  If the Plan does not require the Participant to obtain approval of a specific medical service prior to getting treatment, then there is no pre-service claim. The Participant simply follows the Plan's procedures with

respect to any notice which may be required after receipt of treatment, and files the claim as a post-service claim.

- Concurrent Claims. A "concurrent claim" arises when the Plan has approved an on-going course of treatment to be provided over a period of time or number of treatments, and either:

  - The Plan Administrator determines that the course of treatment should be reduced or terminated; or

  - The Participant requests extension of the course of treatment beyond that which the Plan Administrator has approved.

  If the Plan does not require the Participant to obtain approval of a medical service prior to getting treatment, then there is no need to contact the Plan Administrator to request an extension of a course of treatment. The Participant simply follows the Plan's procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a post-service claim.

- Post-service Claims. A "post-service claim" is a claim for a benefit under the Plan after the services have been rendered.

When Health Claims Must Be Filed
Post-service health claims must be filed with the Third Party Administrator within 365 days of the date charges for the service were incurred. Benefits are based upon the Plan's provisions at the time the charges were incurred. **Claims filed later than that date shall be denied.**

A pre-service claim (including a concurrent claim that also is a pre-service claim) is considered to be filed when the request for approval of treatment or services is made and received by the Third Party Administrator in accordance with the Plan's procedures.

Upon receipt of the required information, the claim will be deemed to be filed with the Plan. The Third Party Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested as provided herein. This additional information must be received by the Contract Administrator within 45 days from receipt by the Participant of the request for additional information. **Failure to do so may result in claims being declined or reduced.**

Timing of Claim Decisions
The Plan Administrator shall notify the Participant, in accordance with the provisions set forth below, of any Adverse Benefit Determination (and, in the case of pre-service claims and concurrent claims, of decisions that a claim is payable in full) within the following timeframes:

- Pre-service Urgent Care Claims:

  - If the Participant has provided all of the necessary information, as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim.

  - If the Participant has not provided all of the information needed to process the claim, then the Participant will be notified as to what specific information is needed as soon as possible, but not later than 72 hours after receipt of the claim.

  - The Participant will be notified of a determination of benefits as soon as possible, but not later than 72 hours, taking into account the medical exigencies, after the earliest of:

    - The Plan's receipt of the specified information; or

    - The end of the period afforded the Participant to provide the information.

- If there is an Adverse Benefit Determination, a request for an expedited appeal may be submitted orally or in writing by the Participant. All necessary information, including the Plan's benefit determination on review, may be transmitted between the Plan and the Participant by telephone, facsimile, or other similarly expeditious method. Alternatively, the Participant may request an expedited review under the external review process.

- Pre-service Non-urgent Care Claims:

  - If the Participant has provided all of the information needed to process the claim, in a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.

  - If the Participant has not provided all of the information needed to process the claim, then the Participant will be notified as to what specific information is needed as soon as possible, but not later than 5 days after receipt of the claim. The Participant will be notified of a determination of benefits in a reasonable period of time appropriate to the medical circumstances, either prior to the end of the extension period (if additional information was requested during the initial processing period), or by the date agreed to by the Plan Administrator and the Participant (if additional information was requested during the extension period).

- Concurrent Claims:

  - Plan Notice of Reduction or Termination. If the Plan Administrator is notifying the Participant of a reduction or termination of a course of treatment (other than by Plan amendment or termination), before the end of such period of time or number of treatments. The Participant will be notified sufficiently in advance of the reduction or termination to allow the Participant to appeal and obtain a determination on review of that Adverse Benefit Determination before the benefit is reduced or terminated. This rule does not apply if benefits are reduced or eliminated due to plan amendment or termination. A similar process applies for claims based on a rescission of coverage for fraud or misrepresentation.

  - Request by Participant Involving Urgent Care. If the Plan Administrator receives a request from a Participant to extend the course of treatment beyond the period of time or number of treatments that is a claim involving urgent care, as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim, as long as the Participant makes the request at least 72 hours prior to the expiration of the prescribed period of time or number of treatments. If the Participant submits the request with less than 24 hours prior to the expiration of the prescribed period of time or number of treatments, the request will be treated as a claim involving urgent care and decided within the urgent care timeframe.

  - Request by Participant Involving Non-urgent Care. If the Plan Administrator receives a request from the Participant to extend the course of treatment beyond the period of time or number of treatments that is a claim not involving urgent care, the request will be treated as a new benefit claim and decided within the timeframe appropriate to the type of claim (either as a pre-service non-urgent claim or a post-service claim).

  - Request by Participant Involving Rescission. With respect to rescissions, the following timetable applies:

    - Notification to Participant 30 days

    - Notification of Adverse Benefit Determination on appeal 30 days

- Post-service Claims:
  - If the Participant has provided all of the information needed to process the claim, in a reasonable period of time, but not later than 30 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.
  - If the Participant has not provided all of the information needed to process the claim and additional information is requested during the initial processing period, then the Participant will be notified of a determination of benefits prior to the end of the extension period, unless additional information is requested during the extension period, then the Participant will be notified of the determination by a date agreed to by the Plan Administrator and the Participant.

- Extensions – Pre-service Urgent Care Claims. No extensions are available in connection with Pre-service urgent care claims.

- Extensions – Pre-service Non-urgent Care Claims. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Participant, prior to the expiration of the initial 15-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

- Extensions – Post-service Claims. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Participant, prior to the expiration of the initial 30-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

- Calculating Time Periods. The period of time within which a benefit determination is required to be made shall begin at the time a claim is deemed to be filed in accordance with the procedures of the Plan.

Notification of an Adverse Benefit Determination

The Plan Administrator shall provide a Participant with a notice, either in writing or electronically (or, in the case of pre-service urgent care claims, by telephone, facsimile or similar method, with written or electronic notice). The notice will state in a culturally and linguistically appropriate manner and in a manner calculated to be understood by the Participant. The notice will contain the following information:

- Information sufficient to allow the Participant to identify the claim involved (including date of service, the healthcare provider, the claim amount, if applicable, and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);

- A reference to the specific portion(s) of the plan provisions upon which a denial is based;

- Specific reason(s) for a denial, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the claim;

- A description of any additional information necessary for the Participant to perfect the claim and an explanation of why such information is necessary;

- A description of the Plan's internal appeals and external review processes and the time limits applicable to the processes. This description will include information on how to initiate the appeal and a statement of the Participant's right to bring a civil action under section 502(a) of ERISA following an Adverse Benefit Determination on final review;

- A statement that the Participant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Participant's claim for benefits;

- The identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request);

- Any rule, guideline, protocol or similar criterion that was relied upon, considered, or generated in making the determination will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol or similar criterion was relied upon in making the determination and a copy will be provided to the Participant, free of charge, upon request;

- In the case of denials based upon a medical judgment (such as whether the treatment is medically necessary or experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Participant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided to the Participant, free of charge, upon request;

- Information about the availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist individuals with the internal claims and appeals and external review processes; and

- In a claim involving urgent care, a description of the Plan's expedited review process.

Appeal Process
In cases where a claim for benefits is denied, in whole or in part, and the Participant believes the claim has been denied wrongly, the Participant may appeal the denial and review pertinent documents. The Plan provides for 2 levels of appeal following an Adverse Benefit Determination. The Participant has 180 days following an initial Adverse Benefit Determination to file an appeal of that determination, and 60 days following a second Adverse Benefit Determination to file an appeal of that determination. To initiate the appeal process, the Third Party Administrator must receive written request from the Participant, or an Authorized Representative of the Participant, with the proper form for review of an Adverse Benefit Determination.

Full and Fair Review of All Claims
The appeal process of this Plan provides a Participant with a reasonable opportunity for a full and fair review of a claim and Adverse Benefit Determination. More specifically, the Plan provides:

- Participants at least 180 days following receipt of a notification of an initial Adverse Benefit Determination within which to appeal the determination;

- Participants at least 60 days following receipt of a second Adverse Benefit Determination within which to appeal the determination;

- Participants the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;

- Participants the opportunity to review the Claim file and to present evidence and testimony as part of the internal claims and appeals process.

- For a review that does not afford deference to the previous Adverse Benefit Determination and that is conducted by an appropriate named fiduciary of the Plan, who shall be neither the individual who made the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual;

- For a review that takes into account all comments, documents, records, and other information submitted by the Participant relating to the claim, without regard to whether such information was submitted or considered in any prior benefit determination;

- That, in deciding an appeal of any Adverse Benefit Determination that is based in whole or in part upon a medical judgment, the Plan fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, who is neither an individual who was consulted in connection with the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of any such individual;

- For the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claim, even if the Plan did not rely upon their advice;

- That a Participant will be provided, free of charge: (a) reasonable access to, and copies of, all documents, records, and other information relevant to the Participant's claim in possession of the Plan Administrator or Third Party Administrator; (b) information regarding any voluntary appeals procedures offered by the Plan; (c) information regarding the Participant's right to an external review process; (d) any internal rule, guideline, protocol or other similar criterion relied upon, considered or generated in making the adverse determination; and (e) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Participant's medical circumstances;

- That a Participant will be provided, free of charge, and sufficiently in advance of the date that the notice of final internal Adverse Benefit Determination is required, with new or additional evidence considered, relied upon, or generated by the Plan in connection with the Claim, as well as any new or additional rationale for a denial at the internal appeals stage, and a reasonable opportunity for the Participant to respond to such new evidence or rationale; and

- The first level of appeal will be the responsibility of the Third Party Administrator and will be decided within 30 days of the Third Party Administrator's receipt of the request. The second level of appeal will be decided within 30 days of the Plan's receipt of the request.

FIRST APPEAL LEVEL

Requirements for Appeal
The Participant must file the first appeal, in writing (although oral appeals are permitted for pre-service urgent care claims), within 180 days following receipt of the notice of an Adverse Benefit Determination. For pre-service urgent care claims, if the Participant chooses to orally appeal, the Participant may telephone:

HealthSCOPE Benefits, Inc.
P.O. Box 2860
Little Rock, AR 72203
1-800-797-1693

To file an appeal in writing, the Participant's appeal must be addressed as follows and mailed or faxed as follows:

HealthSCOPE Benefits, Inc.
P.O. Box 2860
Little Rock, AR 72203
1-800-797-1693

It shall be the responsibility of the Participant to submit proof that the claim for benefits is covered and payable under the provisions of the Plan. Any appeal must include:

- The name of the employee/Participant;

- The employee/Participant's social security number;
- The group name or identification number;
- All facts and theories supporting the claim for benefits. **Failure to include any theories or facts in the appeal will result in their being deemed waived. In other words, the Participant will lose the right to raise factual arguments and theories which support this claim if the Participant fails to include them in the appeal**;
- A statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim; and
- Any material or information that the Participant has which indicates that the Participant is entitled to benefits under the Plan.

If the Participant provides all of the required information, it may be that the expenses will be eligible for payment under the Plan.

Timing of Notification of Benefit Determination on Review
The Plan Administrator shall notify the Participant of the Plan's benefit determination on review within the following timeframes:

- Pre-service Urgent Care Claims: As soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the appeal.
- Pre-service Non-urgent Care Claims: Within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receipt of the appeal.
- Concurrent Claims: The response will be made in the appropriate time period based upon the type of claim – pre-service urgent, pre-service non-urgent or post-service.
- Post-service Claims: Within a reasonable period of time, but not later than 60 days after receipt of the appeal.
- Calculating Time Periods. The period of time within which the Plan's determination is required to be made shall begin at the time an appeal is filed in accordance with the procedures of this Plan, without regard to whether all information necessary to make the determination accompanies the filing.

Manner and Content of Notification of Adverse Benefit Determination on First Appeal
The Plan Administrator shall provide a Participant with notification, with respect to pre-service urgent care claims, by telephone, facsimile or similar method, and with respect to all other types of claims, in writing or electronically, of a Plan's Adverse Benefit Determination on review, setting forth:

- Information sufficient to allow the Participant to identify the claim involved (including date of service, the healthcare provider, the claim amount, if applicable, and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);
- A reference to the specific portion(s) of the plan provisions upon which a denial is based;
- Specific reason(s) for a denial, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the claim, and a discussion of the decision;

- A description of any additional information necessary for the Participant to perfect the claim and an explanation of why such information is necessary;

- A description of available internal appeals and external review processes, including information regarding how to initiate an appeal;

- A description of the Plan's review procedures and the time limits applicable to the procedures. This description will include information on how to initiate the appeal and a statement of the Participant's right to bring a civil action under section 502(a) of ERISA following an Adverse Benefit Determination on final review;

- A statement that the Participant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Participant's claim for benefits;

- The identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request);

- Any rule, guideline, protocol or similar criterion that was relied upon, considered, or generated in making the determination will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol or similar criterion was relied upon in making the determination and a copy will be provided to the Participant, free of charge, upon request;

- In the case of denials based upon a medical judgment (such as whether the treatment is medically necessary or experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Participant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided to the Participant, free of charge, upon request; and

- The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency."

Furnishing Documents in the Event of an Adverse Determination
In the case of an Adverse Benefit Determination on review, the Plan Administrator shall provide such access to, and copies of, documents, records, and other information described in the section relating to "Manner and Content of Notification of Adverse Benefit Determination on Review" as appropriate.

Decision on Review
If, for any reason, the Participant does not receive a written response to the appeal within the appropriate time period set forth above, the Participant may assume that the appeal has been denied. The decision by the Plan Administrator or other appropriate named fiduciary of the Plan on review will be final, binding and conclusive and will be afforded the maximum deference permitted by law. **All claim review procedures provided for in the Plan must be exhausted before any legal action is brought.**

SECOND APPEAL LEVEL

Adverse Decision on First Appeal; Requirements for Second Appeal
Upon receipt of notice of the Plan's Adverse Benefit Determination regarding the first appeal, the Participant has 60 days to file a second appeal of the denial of benefits. The Participant again is entitled to a "full and fair review" of any denial made at the first appeal, which means the Participant has the same rights during the second appeal as he or she had during the first appeal. As with the first appeal, the Participant's second appeal must be in writing and must include all of the items set forth in the section entitled "Requirements for First Appeal."

Timing of Notification of Benefit Determination on Second Appeal
The Plan shall notify the Participant of the Plan's Benefit Determination on review within a reasonable period of time, but not later than 30 days after receipt of the second appeal.

The period of time within which the Plan's determination is required to be made shall begin at the time the second appeal is filed in accordance with the procedures of this Plan, without regard to whether all information necessary to make the determination accompanies the filing.

Manner and Content of Notification of Adverse Benefit Determination on Second Appeal
The same information must be included in the Plan's response to a second appeal as a first appeal, except for: (a) a description of any additional information necessary for the Participant to perfect the Claim and an explanation of why such information is needed; and (b) a description of the Plan's review procedures and the time limits applicable to the procedures. See the section entitled "Notice of Benefit Determination on First Appeal."

Furnishing Documents in the Event of an Adverse Determination
In the case of an Adverse Benefit Determination on the second appeal, the Plan Administrator shall provide such access to, and copies of, documents, records, and other information described in the section relating to the Notice of Benefit Determination on First Appeal, as appropriate.

Decision on Second Appeal to be Final
If, for any reason, the Participant does not receive a written response to the appeal within the appropriate time period set forth above, the Participant may assume that the appeal has been denied. The decision will be final, binding and conclusive, and will be afforded the maximum deference permitted by law. **All Claim review procedures provided for in the Plan must be exhausted before any legal action is brought. Any legal action for the recovery of any benefits must be commenced within 3 years after the Plan's Claim review procedures have been exhausted. Any action with respect to a fiduciary's breach of any responsibility, duty or obligation hereunder must be brought within 3 years after the date of service.**

Appointment of Authorized Representative
A Participant is permitted to appoint an Authorized Representative to act on his behalf with respect to a benefit Claim or appeal of an Adverse Benefit Determination. An assignment of benefits by a Participant to a provider will not constitute appointment of that provider as an Authorized Representative. To appoint such a representative, the Participant must complete a form which can be obtained from the Plan Administrator. In the event a Participant designates an Authorized Representative, all future communications from the Plan will be with the Authorized Representative, rather than the Participant, unless the Participant directs the Plan Administrator, in writing, to the contrary.

External Review Process

A. Scope

1. The Federal external review process does not apply to a denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that a participant or beneficiary fails to meet the requirements for eligibility under the terms of a group health plan.

2. The Federal external review process applies only to:
   (a) An Adverse Benefit Determination (including a final internal Adverse Benefit Determination) by a plan or issuer that involves medical judgment (including, but not limited to, those based on the plan's or issuer's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or its determination that a treatment is experimental or investigational), as determined by the external reviewer; and
   (b) A rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time).

B. Standard external review
Standard external review is external review that is not considered expedited (as described in paragraph B of this section).

1. Request for external review. The Plan will allow a claimant to file a request for an external review with the Plan if the request is filed within 4 months after the date of receipt of a notice of an Adverse Benefit Determination or final internal Adverse Benefit Determination. If there is no corresponding date four months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

2. Preliminary review. Within 5 business days following the date of receipt of the external review request, the Plan will complete a preliminary review of the request to determine whether:
   (a) The claimant is or was covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care item or service was provided;
   (b) The Adverse Benefit Determination or the final Adverse Benefit Determination does not relate to the claimant's failure to meet the requirements for eligibility under the terms of the Plan (e.g., worker classification or similar determination);
   (c) The claimant has exhausted the Plan's internal appeal process unless the claimant is not required to exhaust the internal appeals process under the interim final regulations; and
   (d) The claimant has provided all the information and forms required to process an external review.

   Within 1 business day after completion of the preliminary review, the Plan will issue a notification in writing to the claimant. If the request is complete but not eligible for external review, such notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the request is not complete, such notification will describe the information or materials needed to make the request complete and the Plan will allow a claimant to perfect the request for external review with the four-month filing period or within the 48 hour period following the receipt of the notification, whichever is later.

3. Referral to Independent Review Organization. The Plan will assign an independent review organization (IRO) that is accredited by URAC or by a similar nationally-recognized accrediting organization to conduct the external review. Moreover, the Plan will take action against bias and to ensure independence. Accordingly, the Plan will contract with (or direct the Claims Processor to contract with, on its behalf) at least 3 IROs for assignments under the Plan and rotate claims assignments among them (or incorporate other independent unbiased method for selection of IROs, such as random selection). In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

4. Reversal of Plan's decision. Upon receipt of a notice of a final external review decision reversing the Adverse Benefit Determination or final internal Adverse Benefit Determination, the Plan will provide coverage or payment for the claim without delay, regardless of whether the plan intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise.

C. Expedited external review

Urgent or Emergency Care

This Plan does not require a Participant to obtain prior approval for pre-service urgent care Claims or emergency care services before getting treatment; therefore, neither the internal appeals nor the external review procedures will apply to these Claims. In an emergency or urgent care situation, the Participant should follow instructions from his/her health care provider, and file the Claim as a post-service Claim. If the post-service Claim results in an Adverse Benefit Determination, the Participant may file an appeal in accordance with the Plan's provisions for "Appeal Process", which are explained above.

Appeals of Claims involving concurrent care will be subject to the Plan's provisions for expedited external review, as explained below.

1. Request for expedited external review. The Plan will allow a claimant to make a request for an expedited external review with the Plan at the time the claimant receives:
   (a) An Adverse Benefit Determination if the Adverse Benefit Determination involves a medical condition of the claimant for which the timeframe for completion of a standard internal appeal under the interim final regulations would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function and the claimant has filed a request for an expedited internal appeal; or
   (b) A first internal Adverse Benefit Determination, if the claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function, or if the first internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services, but has not been discharged from a facility.
   (c) A second internal Adverse Benefit Determination, if the claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function, or if the second internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services, but has not been discharged from a facility.

2. Preliminary review. Immediately upon receipt of the request for expedited external review, the Plan will determine whether the request meets the reviewability requirements set forth in paragraph B.2 above for standard external review. The Plan will immediately send a notice that meets the requirements set forth in paragraph B.2 above for standard external review to the claimant of its eligibility determination.

3. Referral to independent review organization. Upon a determination that a request is eligible for external review following the preliminary review, the Plan will assign an IRO pursuant to the requirements set forth in paragraph B.3 above for standard review. The Plan will provide or transmit all necessary documents and information considered in making the Adverse Benefit Determination or final internal Adverse Benefit Determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.

   The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO will review the claim de novo and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process.

4. Notice of final external review decision. The Plan's (or Claim Processor's) contract with the assigned IRO will require the IRO to provide notice of the final external review decision, as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO will provide written confirmation of the decision to the claimant and the Plan.

10.02 Deemed Exhaustion of Internal Claims Procedures and De Minimis

Exception to the Deemed Exhaustion Rule

A Participant will not be required to exhaust the internal claims and appeals procedures described above if the Plan fails to adhere to the claims procedures requirements. In such an instance, a Participant may proceed immediately to the External Review Program or make a claim in court. However, the internal claim and appeals procedures will not be deemed exhausted (meaning the Participant must adhere to them before participating in the External Review

Program or bringing a claim in court) in the event of a de minimis violation that does not cause, and is not likely to cause, prejudice or harm to the Participant as long as the Plan Administrator demonstrates that the violation was for good cause or due to matters beyond the control of the Plan, the violation occurred in the context of an ongoing, good faith exchange of information between the Plan and the Participant, and the violation is not reflective of a pattern or practice of non- compliance.

If a Participant believes the Plan Administrator has engaged in a violation of the claims procedures and would like to pursue an immediate review, the Participant may request that the Plan provide a written explanation of the violation, including a description of the Plan's basis for asserting that the violation should not result in a "deemed exhaustion" of the claims procedures. The Plan will respond to this request within ten days. If the External Reviewer or a court rejects a request for immediate review because the Plan has met the requirements for the "de minimis" exception described above, the Plan will provide the Participant with notice of an opportunity to resubmit and pursue an internal appeal of the claim.

10.03 Appointment of Authorized Representative

A Participant is permitted to appoint an authorized representative to act on his or her behalf with respect to a benefit claim or appeal of a denial. An assignment of benefits by a Participant to a Provider will not constitute appointment of that Provider as an authorized representative. To appoint such a representative, the Participant must complete a form which can be obtained from the Plan Administrator or the Third Party Administrator. However, in connection with a claim involving Urgent Care, the Plan will permit a health care professional with knowledge of the Participant's medical condition to act as the Participant's authorized representative without completion of this form. In the event a Participant designates an authorized representative, all future communications from the Plan will be with the representative, rather than the Participant, unless the Participant directs the Plan Administrator, in writing, to the contrary.

10.04 Physical Examinations

The Plan reserves the right to have a Physician of its own choosing examine any Participant whose condition, Sickness or Injury is the basis of a claim. All such examinations shall be at the expense of the Plan. This right may be exercised when and as often as the Plan may reasonably require during the pendency of a claim. The Participant must comply with this requirement as a necessary condition to coverage.

10.05 Autopsy

The Plan reserves the right to have an autopsy performed upon any deceased Participant whose condition, Sickness, or Injury is the basis of a claim. This right may be exercised only where not prohibited by law.

10.06 Payment of Benefits

All benefits under this Plan are payable, in U.S. Dollars, to the covered Employee whose Sickness or Injury, or whose covered Dependent's Sickness or Injury, is the basis of a claim. In the event of the death or incapacity of a covered Employee and in the absence of written evidence to this Plan of the qualification of a guardian for his or her estate, this Plan may, in its sole discretion, make any and all such payments to the individual or institution which, in the opinion of this Plan, is or was providing the care and support of such Employee.

10.06A Assignments

Benefits for medical expenses covered under this Plan may be assigned by a Participant to the Provider as consideration in full for services rendered; however, if those benefits are paid directly to the Employee, the Plan shall be deemed to have fulfilled its obligations with respect to such benefits. The Plan will not be responsible for determining whether any such assignment is valid. Payment of benefits which have been assigned will be made directly to the assignee unless a written request not to honor the assignment, signed by the covered Employee and the assignee, has been received before the proof of loss is submitted.

No Participant shall at any time, either during the time in which he or she is a Participant in the Plan, or following his or her termination as a Participant, in any manner, have any right to assign his or her right to sue to recover benefits under the Plan, to enforce rights due under the Plan or to any other causes of action which he or she may have against the Plan or its fiduciaries.

A Provider which accepts an assignment of benefits, in accordance with this Plan as consideration in full for services rendered, is bound by the rules and provisions set forth within the terms of this document.

10.06B Recovery of Payments

Occasionally, benefits are paid more than once, are paid based upon improper billing or a misstatement in a proof of loss or enrollment information, are not paid according to the Plan's terms, conditions, limitations or exclusions, or should otherwise not have been paid by the Plan. As such this Plan may pay benefits that are later found to be greater than the Maximum Allowable Charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid, primary payers, or from the party on whose behalf the charge(s) were paid. As such, whenever the Plan pays benefits exceeding the amount of benefits payable under the terms of the Plan, the Plan Administrator has the right to recover any such erroneous payment directly from the person or entity who received such payment and/or from other payers and/or the Plan Participant or dependent on whose behalf such payment was made.

A Plan Participant, Dependent, Provider, another benefit plan, insurer, or any other person or entity who receives a payment exceeding the amount of benefits payable under the terms of the Plan or on whose behalf such payment was made, shall return or refund the amount of such erroneous payment to the Plan within 30 days of discovery or demand. The Plan Administrator shall have no obligation to secure payment for the expense for which the erroneous payment was made or to which it was applied.

The person or entity receiving an erroneous payment may not apply such payment to another expense. The Plan Administrator shall have the sole discretion to choose who will repay the Plan for an erroneous payment and whether such payment shall be reimbursed in a lump sum. When a Plan Participant or other entity does not comply with the provisions of this section, the Plan Administrator shall have the authority, in its sole discretion, to deny payment of any claims for benefits by the Plan Participant and to deny or reduce future benefits payable (including payment of future benefits for other injuries or illnesses) under the Plan by the amount due as reimbursement to the Plan. The Plan Administrator may also, in its sole discretion, deny or reduce future benefits (including future benefits for other injuries or illnesses) under any other group benefits plan maintained by the Plan Sponsor. The reductions will equal the amount of the required reimbursement.

Providers and any other person or entity accepting payment from the Plan or to whom a right to benefits has been assigned, in consideration of services rendered, payments and/or rights, agrees to be bound by the terms of this Plan and agree to submit claims for reimbursement in strict accordance with their State's health care practice acts, ICD-10 or CPT standards, Medicare guidelines, HCPCS standards, or other standards approved by the Plan Administrator or insurer. Any payments made on claims for reimbursement not in accordance with the above provisions shall be repaid to the Plan within 30 days of discovery or demand or incur prejudgment interest of 1.5% per month. If the Plan must bring an action against a Plan Participant, Provider or other person or entity to enforce the provisions of this section, then that Plan Participant, Provider or other person or entity agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

Further, Plan Participants and/or their dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (Plan Participants) shall assign or be deemed to have assigned to the Plan their right to recover said payments made by the Plan, from any other party and/or recovery for which the Plan Participant(s) are entitled, for or in relation to facility-acquired condition(s), Provider error(s), or damages arising from another party's act or omission for which the Plan has not already been refunded.

The Plan reserves the right to deduct from any benefits properly payable under this Plan the amount of any payment which has been made:

1. In error;
2. Pursuant to a misstatement contained in a proof of loss or a fraudulent act;
3. Pursuant to a misstatement made to obtain coverage under this Plan within two years after the date such coverage commences;
4. With respect to an ineligible person;

5. In anticipation of obtaining a recovery if a Plan Participant fails to comply with the Plan's Third Party Recovery, Subrogation and Reimbursement provisions; or
6. Pursuant to a claim for which benefits are recoverable under any policy or act of law providing for coverage for occupational Injury or disease to the extent that such benefits are recovered. This provision (6) shall not be deemed to require the Plan to pay benefits under this Plan in any such instance.

The deduction may be made against any claim for benefits under this Plan by a Plan Participant or by any of his Covered Dependents if such payment is made with respect to the Plan Participant or any person covered or asserting coverage as a Dependent of the Plan Participant.

If the Plan seeks to recoup funds from a Provider, due to a claim being made in error, a claim being fraudulent on the part of the Provider, and/or the claim that is the result of the Provider's misstatement, said Provider shall, as part of its assignment to benefits from the Plan, abstain from billing the plan participant for any outstanding amount(s).

10.06C Medicaid Coverage

A Participant's eligibility for any State Medicaid benefits will not be taken into account in determining or making any payments for benefits to or on behalf of such Participant. Any such benefit payments will be subject to the State's right to reimbursement for benefits it has paid on behalf of the Participant, as required by the State Medicaid program; and the Plan will honor any Subrogation rights the State may have with respect to benefits which are payable under the Plan.

10.06E Limitation of Action

A Participant cannot bring any legal action against the Company or the Third Party Administrator to recover reimbursement until 90 days after the Participant has properly submitted a request for reimbursement as described in this section and all required reviews of the Participant's claim have been completed. If the Participant wants to bring a legal action against the Company or the Third Party Administrator, he/she must do so within 3 years from the expiration of the time period in which a request for reimbursement must be submitted or he/she loses any rights to bring such an action against the Company or the Third Party Administrator.

A Participant cannot bring any legal action against the Company or the Third Party Administrator for any other reason unless he/she first completes all the steps in the appeal process described in this section. After completing that process, if he/she wants to bring a legal action against the Company or the Third Party Administrator he/she must do so within 3 years of the date he/she is notified of the final decision on the appeal or he/she will lose any rights to bring such an action against the Company or the Third Party Administrator.

ARTICLE XI
COORDINATION OF BENEFITS

11.01 Benefits Subject to This Provision
This provision shall apply to all benefits provided under any section of this Plan.

11.02 Excess Insurance
If at the time of injury, sickness, disease or disability there is available, or potentially available any Coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage.

The Plan's benefits will be excess to, whenever possible:

a) Any primary payer besides the Plan;
b) Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
c) Any policy of insurance from any insurance company or guarantor of a third party;
d) Worker's compensation or other liability insurance company; or
e) Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

11.03 Vehicle Limitation
When medical payments are available under any vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan and/or policy deductibles. This Plan shall always be considered secondary to such plans and/or policies. This applies to all forms of medical payments under vehicle plans and/or policies regardless of its name, title or classification.

11.04 Allowable Expenses
"Allowable Expenses" shall mean the Usual and Customary charge for any Medically Necessary, Reasonable, eligible item of expense, at least a portion of which is covered under a plan. When some Other Plan pays first in accordance with Section 10.06A herein, this Plan's Allowable Expenses shall consist of the Plan Participant's responsibility, if any, after the Other Plan has paid but shall in no event exceed the Other Plan's Allowable Expenses. When some Other Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered, in the amount that would be payable in accordance with the terms of the Plan, shall be deemed to be the benefit. Benefits payable under any Other Plan include the benefits that would have been payable had claim been duly made therefore.

11.05 "Claim Determination Period"
"Claim Determination Period" shall mean each calendar year.

11.06 Effect on Benefits:

11.06A Application to Benefit Determinations
The plan that pays first according to the rules in the section entitled "Order of Benefit Determination" will pay as if there were no other plan involved. The secondary and subsequent plans will pay the balance due up to 100% of the plan's Allowable Expenses. Benefits will be coordinated on the basis of a Claim Determination Period.

When medical payments are available under automobile insurance, this Plan will pay excess benefits only, without reimbursement for automobile plan deductibles. This Plan will always be considered the secondary carrier regardless of the individual's election under personal injury protection (PIP) coverage with the automobile insurance carrier.

In certain instances, the benefits of the Other Plan will be ignored for the purposes of determining the benefits under this Plan. This is the case when:

1. The Other Plan would, according to its rules, determine its benefits after the benefits of this Plan have been determined; and
2. The rules in the section entitled "Order of Benefit Determination" would require this Plan to determine its benefits before the Other Plan.

11.06B Order of Benefit Determination

For the purposes of the section entitled "Application to Benefit Determinations," the rules establishing the order of benefit determination are:

1. A plan without a coordinating provision will always be the primary plan;
2. The benefits of a plan which covers the person on whose expenses claim is based, other than as a dependent, shall be determined before the benefits of a plan which covers such person as a dependent;
3. If the person for whom claim is made is a dependent child covered under both parents' plans, the plan covering the parent whose birthday (month and day of birth, not year) falls earlier in the year will be primary, except:

    a. When the parents are separated or divorced, and the parent with the custody of the child has not remarried, the benefits of a plan which covers the child as a dependent of the parent with custody will be determined before the benefits of a plan which covers the child as a dependent of the parent without custody; or
    b. When the parents are divorced and the parent with custody of the child has remarried, the benefits of a plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a plan which covers that child as a dependent of the stepparent, and the benefits of a plan which covers that child as a dependent of the stepparent will be determined before the benefits of a plan which covers that child as a dependent of the parent without custody.

    Notwithstanding the above, if there is a court decree which would otherwise establish financial responsibility for the child's health care expenses, the benefits of the plan which covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any Other Plan which covers the child as a dependent child; and

4. When the rules above do not establish an order of benefit determination, the benefits of a plan which has covered the person on whose expenses claim is based for the longer period of time shall be determined before the benefits of a plan which has covered such person the shorter period of time.

11.07 Right to Receive and Release Necessary Information

For the purpose of determining the applicability of and implementing the terms of this provision or any provision of similar purpose of any Other Plan, this Plan may, without the consent of or notice to any person, release to or obtain from any insurance company, or other organization or individual, any information with respect to any person, which the Plan deems to be necessary for such purposes. Any person claiming benefits under this Plan shall furnish to the Plan such information as may be necessary to implement this provision.

11.08 Facility of Payment

Whenever payments which should have been made under this Plan in accordance with this provision have been made under any Other Plans, the Plan Administrator may, in its sole discretion, pay any organizations making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision, and amounts so paid shall be deemed to be benefits paid under this Plan and, to the extent of such payments, this Plan shall be fully discharged from liability.

11.09 Right of Recovery

In accordance with section 10.06C, whenever payments have been made by this Plan with respect to Allowable Expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this Article, the Plan shall have the right to recover such payments, to the extent of such excess, from any one or more of the following as this Plan shall determine: any person to or with respect to whom such

payments were made, or such person's legal representative, any insurance companies, or any other individuals or organizations which the Plan determines are responsible for payment of such Allowable Expenses, and any future benefits payable to the Participant or his or her Dependents. **Please see 10.06C above for more details.**

ARTICLE XII
MEDICARE

12.01 Applicable to Active Employees and Their Spouses Ages 65 and Over

An active Employee and his or her spouse (ages 65 and over) may, at the option of such Employee, elect or reject coverage under this Plan. If such Employee elects coverage under this Plan, the benefits of this Plan shall be determined before any benefits provided by Medicare. If coverage under this Plan is rejected by such Employee, benefits listed herein will not be payable even as secondary coverage to Medicare.

12.02 Applicable to All Other Participants Eligible for Medicare Benefits

To the extent required by Federal regulations, this Plan will pay before any Medicare benefits. There are some circumstances under which Medicare would be required to pay its benefits first. In these cases, benefits under this Plan would be calculated as secondary payor (as described under the Article entitled "Coordination of Benefits"). The Participant will be assumed to have full Medicare coverage (that is, both Part A & B) whether or not the Participant has enrolled for the full coverage. If the Provider accepts assignment with Medicare, covered expenses will not exceed the Medicare-approved expenses.

12.03 Applicable to Medicare Services Furnished to End Stage Renal Disease ("ESRD") Plan Participants Who Are Covered Under This Plan

If any Participant is eligible for Medicare benefits because of ESRD, the benefits of the Plan will be determined before Medicare benefits for the first 18 months of Medicare entitlement (with respect to charges incurred on or after February 1, 1991 and before August 5, 1997), and for the first 30 months of Medicare entitlement (with respect to charges incurred on or after August 5, 1997), unless applicable Federal law provides to the contrary, in which event the benefits of the Plan will be determined in accordance with such law.

ARTICLE XIII
THIRD PARTY RECOVERY, SUBROGATION AND REIMBURSEMENT

13.01 Payment Condition

1. The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an injury, sickness, disease or disability is caused in whole or in part by, or results from the acts or omissions of Plan Participants, and/or their dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Plan Participant(s)") or a third party, where any party besides the Plan may be responsible for expenses arising from an incident, and/or other funds are available, including but not limited to no-fault, uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or grantor(s) of a third party (collectively "Coverage").

2. Plan Participant(s), his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain one hundred percent (100%) of the Plan's conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. By accepting benefits the Plan Participant(s) agrees the Plan shall have an equitable lien on any funds received by the Plan Participant(s) and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Plan Participant(s) agrees to include the Plan's name as a co-payee on any and all settlement drafts.

3. In the event a Plan Participant(s) settles, recovers, or is reimbursed by any Coverage, the Plan Participant(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Plan Participant(s). If the Plan Participant(s) fails to reimburse the Plan out of any judgment or settlement received, the Plan Participant(s) will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money.

4. If there is more than one party responsible for charges paid by the Plan, or may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the Plan Participant(s) is/are only one or a few, that unallocated settlement fund is considered designated as an "identifiable" fund from which the plan may seek reimbursement.

13.02 Subrogation

1. As a condition to participating in and receiving benefits under this Plan, the Plan Participant(s) agrees to assign to the Plan the right to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the Plan Participant(s) is entitled, regardless of how classified or characterized, at the Plan's discretion.

2. If a Plan Participant(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Plan Participant(s) may have against any Coverage and/or party causing the sickness or injury to the extent of such conditional payment by the Plan plus reasonable costs of collection.

3. The Plan may, at its discretion, in its own name or in the name of the Plan Participant(s) commence a proceeding or pursue a claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.

4. If the Plan Participant(s) fails to file a claim or pursue damages against:

    a) The responsible party, its insurer, or any other source on behalf of that party;

b) Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
c) Any policy of insurance from any insurance company or guarantor of a third party;
d) Worker's compensation or other liability insurance company; or
e) Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage;

the Plan Participant(s) authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Plan Participant(s)' and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Plan Participant(s) assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

13.03 Right of Reimbursement

1. The Plan shall be entitled to recover 100% of the benefits paid, without deduction for attorneys' fees and costs or application of the common fund doctrine, make whole doctrine, or any other similar legal theory, without regard to whether the Plan Participant(s) is fully compensated by his/her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any State prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. If the Plan Participant(s)' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved.

2. No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, expressed written consent of the Plan.

3. The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Plan Participant(s), whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.

4. These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Plan Participant(s).

5. This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable sickness, injury, disease or disability.

13.04 Excess Insurance

1. If at the time of injury, sickness, disease or disability there is available, or potentially available any Coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage, except as otherwise provided for under the Plan's Coordination of Benefits section.

   The Plan's benefits shall be excess to:

   a) The responsible party, its insurer, or any other source on behalf of that party;
   b) Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
   c) Any policy of insurance from any insurance company or guarantor of a third party;
   d) Worker's compensation or other liability insurance company; or
   e) Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

13.05 Separation of Funds

Benefits paid by the Plan, funds recovered by the Plan Participant(s), and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Plan Participant(s), such that the death of the Plan Participant(s), or filing of bankruptcy by the Plan Participant(s), will not affect the Plan's equitable lien, the funds over which the Plan has a lien, or the Plan's right to subrogation and reimbursement.

13.06 Wrongful Death

In the event that the Plan Participant(s) dies as a result of his or her injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply.

13.07 Obligations

1. It is the Plan Participant(s)' obligation at all times, both prior to and after payment of medical benefits by the Plan:

    a) To cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights;
    b) To provide the Plan with pertinent information regarding the sickness, disease, disability, or injury, including accident reports, settlement information and any other requested additional information;
    c) To take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights;
    d) To do nothing to prejudice the Plan's rights of subrogation and reimbursement;
    e) To promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received; and
    f) To not settle or release, without the prior consent of the Plan, any claim to the extent that the Plan Participant may have against any responsible party or Coverage.

2. If the Plan Participant(s) and/or his or her attorney fails to reimburse the Plan for all benefits paid or to be paid, as a result of said injury or condition, out of any proceeds, judgment or settlement received, the Plan Participant(s) will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Plan Participant(s).

3. The Plan's rights to reimbursement and/or subrogation are in no way dependent upon the Plan Participant(s)' cooperation or adherence to these terms.

13.08 Offset

Failure by the Plan Participant(s) and/or his or her attorney to comply with any of these requirements may, at the Plan's discretion, result in a forfeiture of payment by the Plan of medical benefits and any funds or payments due under this Plan on behalf of the Plan Participant(s) may be withheld until the Plan Participant(s) satisfies his or her obligation.

13.09 Minor Status

1. In the event the Plan Participant(s) is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned.

2. If the minor's parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

13.10 Language Interpretation

The Plan Administrator retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the Plan's subrogation and reimbursement rights. The Plan Administrator may amend the Plan at any time without notice.

13.11 Severability

In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The section shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

ARTICLE XIV
MISCELLANEOUS PROVISIONS

14.01 Applicable Law

This is a self-funded benefit plan coming within the purview of the Employee Retirement Income Security Act of 1974 ("ERISA"). The Plan is funded with employee and/or employer contributions. As such, when applicable, Federal law and jurisdiction preempt State law and jurisdiction.

14.02 Clerical Error/Delay

Clerical errors made on the records of the Plan and delays in making entries on such records shall not invalidate coverage nor cause coverage to be in force or to continue in force. Rather, the Effective Dates of coverage shall be determined solely in accordance with the provisions of this Plan regardless of whether any contributions with respect to Participants have been made or have failed to be made because of such errors or delays. Upon discovery of any such error or delay, an equitable adjustment of any such contributions will be made.

14.03 Conformity With Applicable Laws

This Plan shall be deemed to automatically be amended to conform as required by any applicable law, regulation or the order or judgment of a court of competent jurisdiction governing provisions of this Plan, including, but not limited to, stated maximums, exclusions or limitations. In the event that any law, regulation or the order or judgment of a court of competent jurisdiction causes the Plan Administrator to pay claims which are otherwise limited or excluded under this Plan, such payments will be considered as being in accordance with the terms of this Plan Document. It is intended that the Plan will conform to the requirements of ERISA, as it applies to employee welfare plans, as well as any other applicable law.

14.04 Fraud

The following actions by any Participant, or a Participant's knowledge of such actions being taken by another, constitute fraud and will result in immediate termination of all coverage under this Plan for the entire Family Unit of which the Participant is a member:

1. Attempting to submit a claim for benefits (which includes attempting to fill a prescription) for a person who is not a Participant of the Plan;
2. Attempting to file a claim for a Participant for services which were not rendered or Drugs or other items which were not provided;
3. Providing false or misleading information in connection with enrollment in the Plan; or
4. Providing any false or misleading information to the Plan.

14.05 Headings

The headings used in this Plan Document are used for convenience of reference only. Participants are advised not to rely on any provision because of the heading.

14.06 No Waiver or Estoppel

No term, condition or provision of this Plan shall be deemed to have been waived, and there shall be no estoppel against the enforcement of any provision of this Plan, except by written instrument of the party charged with such waiver or estoppel. No such written waiver shall be deemed a continuing waiver unless specifically stated therein, and each such waiver shall operate only as to the specific term or condition waived and shall not constitute a waiver of such term or condition for the future or as to any act other than the one specifically waived.

14.07 Plan Contributions

The Plan Administrator shall, from time to time, evaluate the funding method of the Plan and determine the amount to be contributed by the Participating Employer and the amount to be contributed (if any) by each Participant.

The Plan Sponsor shall fund the Plan in a manner consistent with the provisions of the Internal Revenue Code, ERISA, and such other laws and regulations as shall be applicable to the end that the Plan shall be funded on a lawful and sound basis; but, to the extent permitted by governing law, the Plan Administrator shall be free to

determine the manner and means of funding the Plan. The amount of the Participant's contribution (if any) will be determined from time to time by the Plan Administrator.

14.08 Right to Receive and Release Information

For the purpose of determining the applicability of and implementing the terms of these benefits, the Plan Administrator may, without the consent of or notice to any person, release or obtain any information necessary to determine the acceptability of any applicant or Participant for benefits from this Plan. In so acting, the Plan Administrator shall be free from any liability that may arise with regard to such action. Any Participant claiming benefits under this Plan shall furnish to the Plan Administrator such information as may be necessary to implement this provision.

14.09 Written Notice

Any written notice required under this Plan which, as of the Effective Date, is in conflict with the law of any governmental body or agency which has jurisdiction over this Plan shall be interpreted to conform to the minimum requirements of such law.

14.10 Right of Recovery

In accordance with 10.06C, whenever payments have been made by this Plan in a total amount, at any time, in excess of the maximum amount of benefits payable under this Plan, the Plan shall have the right to recover such payments, to the extent of such excess, from any one or more of the following as this Plan shall determine: any person to or with respect to whom such payments were made, or such person's legal representative, any insurance companies, or any other individuals or organizations which the Plan determines are responsible for payment of such amount, and any future benefits payable to the Participant or his or her Dependents. **See 10.06C above for full details**.

14.11 Statements

All statements made by the Company or by a Plan Participant will, in the absence of fraud, be considered representations and not warranties, and no statements made for the purpose of obtaining benefits under this document will be used in any contest to avoid or reduce the benefits provided by the document unless contained in a written application for benefits and a copy of the instrument containing such representation is or has been furnished to the Plan Participant.

Any Plan Participant who knowingly and with intent to defraud the Plan, files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any material fact, commits a fraudulent act. The Plan Participant may be subject to prosecution by the United States Department of Labor. Fraudulently claiming benefits may be punishable by a substantial fine, imprisonment, or both.

14.12 Binding Arbitration

***Note**: You are enrolled in a plan provided by your Employer that is subject to ERISA, any dispute involving an adverse benefit decision must be resolved under ERISA's claims procedure rules, and is not subject to mandatory binding arbitration. You may pursue voluntary binding arbitration after you have completed an appeal under ERISA. If you have any other dispute which does not involve an adverse benefit decision, this Binding Arbitration provision applies.*

Any dispute or claim, of whatever nature, arising out of, in connection with, or in relation to this Plan, or breach or rescission thereof, or in relation to care or delivery of care, including any claim based on contract, tort or statute, must be resolved by arbitration if the amount sought exceeds the jurisdictional limit of the small claims court. Any dispute regarding a claim for damages within the jurisdictional limits of the small claims court will be resolved in such court.

The Federal Arbitration Act shall govern the interpretation and enforcement of all proceedings under this BINDING ARBITRATION provision. To the extent that the Federal Arbitration Act is inapplicable, or is held not to require arbitration of a particular claim, State law governing agreements to arbitrate shall apply.

The Participant and the Plan Administrator agree to be bound by this Binding Arbitration provision and acknowledge that they are each giving up their right to a trial by court or jury.

The Participant and the Plan Administrator agree to give up the right to participate in class arbitration against each other. Even if applicable law permits class actions or class arbitrations, the Participant waives any right to pursue, on a class basis, any such controversy or claim against the Plan Administrator and the Plan Administrator waives any right to pursue on a class basis any such controversy or claim against the Participant.

The arbitration findings will be final and binding except to the extent that State or Federal law provides for the judicial review of arbitration proceedings.

The arbitration is begun by the Participant making written demand on the Plan Administrator. The arbitration will be conducted by Judicial Arbitration and Mediation Services ("JAMS") according to its applicable Rules and Procedures. If, for any reason, JAMS is unavailable to conduct the arbitration, the arbitration will be conducted by another neutral arbitration entity, by mutual agreement of the Participant and the Plan Administrator, or by order of the court, if the Participant and the Plan Administrator cannot agree.

The costs of the arbitration will be allocated per the JAMS Policy on Consumer Arbitrations. If the arbitration is not conducted by JAMS, the costs will be shared equally by the parties, except in cases of extreme financial hardship, upon application to the neutral arbitration entity to which the parties have agreed, in which cases, the Plan Administrator will assume all or a portion of the costs of the arbitration.

14.13 Unclaimed Self-Insured Plan Funds

In the event a benefits check issued by the Third Party Administrator for this self-insured Plan is not cashed within one year of the date of issue, the check will be voided and the funds will be returned to this Plan and applied to the payment of current benefits and administrative fees under this Plan. In the event a Participant subsequently requests payment with respect to the voided check, the Third Party Administrator for the self-insured Plan shall make such payment under the terms and provisions of the Plan as in effect when the claim was originally processed. Unclaimed self-insured Plan funds may be applied only to the payment of benefits (including administrative fees) under the Plan pursuant to ERISA and any other applicable State law(s).

ARTICLE XV
MEDICAL BENEFITS

15.01 Medical Benefits

Subject to the Plan's provisions, limitations and exclusions, the following are covered major medical benefits:

1. **Allergy Services.** Charges related to the Treatment of allergies;

2. **Ambulance (ground).** Transportation by professional ambulance, including approved available train transportation, to a local Hospital or transfer to the nearest facility having the capability to treat the condition, if the transportation is connected with an Inpatient Confinement.

   Ambulance (air/flight). Inter-facility patient transport by air transport, for Participants if there is a life threatening situation or it is deemed to be Medically Necessary.

   For a Participant who is in a Hospital or other health care facility under the care or supervision of a licensed health care Provider pre-certification is required before transport of the Participant via air transport / any form of flight to another Hospital or facility.

   Failure to notify Sentinel Air Medical Alliance, LLC and subsequently obtain a pre-certification number from Sentinel Air Medical Alliance, LLC may, solely in the Plan Administrator's discretion, result in a reduction or denial of benefits for charges arising from or related to inter-facility patient transport via air/flight. Non-compliance penalties imposed for failure to notify Sentinel Air Medical Alliance, LLC will not be included as part of the annual out of pocket maximum.

   The Plan Administrator retains the discretionary authority to limit benefit availability to alternative Providers of flight-based inter-facility patient transport if and when a Provider fails to comply with the terms of the Plan, or proposed charges exceed the Maximum Allowable Charge in accordance with the terms of the Plan;

3. **Ambulatory Surgical Center.** Services of an Ambulatory Surgical Center for Medically Necessary care provided;

4. **Anesthesia.** Anesthesia, anesthesia supplies, and administration of anesthesia by facility staff;

5. **Birthing Center**. Services of a Birthing Center for Medically Necessary care provided within the scope of its license;

6. **Blood and Plasma.** Blood transfusions, plasma and blood derivatives and charges for whole blood not donated or replaced by a blood bank;

7. **Chemotherapy.** Charges for chemotherapy. The Plan shall refer to the Centers for Medicare & Medicaid Services (CMS) authoritative compendia, including the NCCN Drugs and Biologics Compendium and Thomson Micromedex, in the determination of medically accepted drugs and biologicals used off-label in an anti-cancer chemotherapeutic regimen;

8. **Chiropractic Care.** Spinal adjustment and manipulation, x-rays for manipulation and adjustment and other modalities performed by a Physician or other licensed practitioner, as limited in the Summary of Benefits;

9. **Contraceptives.** The charges for all FDA approved contraceptives methods, in accordance with Health Resources and Services Administration (HRSA) guidelines;

10. **Dental.** Emergency repair due to Injury to sound natural teeth, if the repair is made within 12 months from the date of the Injury (unless otherwise required by applicable law);

11. **Diagnostic Tests; Examinations.** Charges for x-rays, microscopic tests, laboratory tests, esophagoscopy, gastroscopy, proctosigmoidoscopy, colonoscopy and other diagnostic tests and procedures;

12. **Dialysis Treatment - Outpatient**.
This Section describes the Plan's Dialysis Benefit Preservation Program (the "Dialysis Program"). The Dialysis Program shall be the exclusive means for determining the amount of Plan benefits to be provided to Plan members and for managing cases and claims involving dialysis services and supplies, regardless of the condition causing the need for dialysis.
    A. Reasons for the Dialysis Program. The Dialysis Program has been established for the following reasons:
        (1) the concentration of dialysis providers in the market in which Plan members reside may allow such providers to exercise control over prices for dialysis-related products and services,
        (2) the potential for discrimination by dialysis providers against the Plan because it is a non-governmental and non-commercial health plan, which discrimination may lead to increased prices for dialysis-related products and services charged to Plan members,
        (3) evidence of (i) significant inflation of the prices charged to Plan members by dialysis providers, (ii) the use of revenues from claims paid on behalf of Plan members to subsidize reduced prices to other types of payers as incentives, and (iii) the specific targeting of the Plan and other non-governmental and non-commercial plans by the dialysis providers as profit centers, and
        (4) the fiduciary obligation to preserve Plan assets against charges which (i) exceed reasonable value due to factors not beneficial to Plan members, such as market concentration and discrimination in charges, and (ii) are used by the dialysis providers for purposes contrary to the Plan members' interests, such as subsidies for other plans and discriminatory profit-taking.
    B. Dialysis Program Components. The components of the Dialysis Program are as follows:
        (1) Application. The Dialysis Program shall apply to all claims filed by, or on behalf of, Plan members for reimbursement of products and services provided for purposes of outpatient dialysis, regardless of the condition causing the need for dialysis ("dialysis-related claims").
        (2) Claims Affected. The Dialysis Program shall apply to all dialysis-related claims received by the Plan on or after September 1, 2013, regardless when the expenses related to such claim were incurred or when the initial claim for such products or services was received by the Plan with respect to the Plan member.
        (3) Mandated Cost Review. All dialysis-related claims will be subject to cost review by the Plan Administrator to determine whether the charges indicate the effects of market concentration or discrimination in charges. In making this determination the Plan Administrator shall consider factors including:
            i. Market concentration: The Plan Administrator shall consider whether the market for outpatient dialysis products and services is sufficiently concentrated to permit providers to exercise control over charges due to limited competition, based on reasonably available data and authorities. For purposes of this consideration multiple dialysis facilities under common ownership or control shall be counted as a single provider.
            ii. Discrimination in charges: The Plan Administrator shall consider whether the claims reflect potential discrimination against the Plan, by comparison of the charges in such claims against reasonably available data about payments to outpatient dialysis providers by governmental and commercial plans for the same or materially comparable goods and services.
        (4) In the event that the Plan Administrator's charge review indicates a reasonable probability that market concentration and/or discrimination in charges have been a material factors resulting in an increase of the charges for outpatient dialysis products and/or services for the dialysis-related claims under review, the Plan Administrator may, in its sole

discretion, determine that there is a reasonable probability that the charges exceed the reasonable value of the goods and/or services. Based upon such a determination, the Plan Administrator may subject the claims and all future claims for outpatient dialysis goods and services from the same provider with respect to the Plan member, to the following payment limitations, under the following conditions:

i. Where the Plan Administrator deems it appropriate in order to minimize disruption and administrative burdens for the Plan member, dialysis-related claims received prior to the cost review determination may, but are not required to be, paid at the face or otherwise applicable rate.

ii. Where the provider is or has been a participating provider under a Preferred Provider Organization (PPO) available to the Plan's members, upon the Plan Administrator's determination that payment limitations should be implemented, the rate payable to such provider shall be subject to the limitations of this Section.

iii. Maximum Benefit. The maximum Plan benefit payable to dialysis-related claims subject to the payment limitation shall be the Usual and Reasonable Charge for covered services and/or supplies, after deduction of all amounts payable by coinsurance or deductibles.

iv. Usual and Reasonable Charge. With respect to dialysis-related claims, the Plan Administrator shall determine the Usual and Reasonable Charge based upon the average payment actually made for reasonably comparable services and/or supplies to all providers of the same services and/or supplies by all types of plans in the applicable market during the preceding calendar year, based upon reasonably available data, adjusted for the national Consumer Price Index medical care rate of inflation. The Plan Administrator may increase or decrease the payment based upon factors concerning the nature and severity of the condition being treated.

v. Additional Information related to Value of Dialysis-Related Services and Supplies. The Plan member, or where the right to Plan benefits has been properly assigned to the provider, may provide information with respect to the reasonable value of the supplies and/or services, for which payment is claimed, on appeal of the denial of any claim or claims. In the event the Plan Administrator, in its sole discretion, determines that such information demonstrates that the payment for the claim or claims did not reflect the reasonable value, the Plan Administrator shall increase or decrease the payments (as applicable) to the amount of the reasonable value, as determined by the Plan Administrator based upon credible information from identified sources. The Plan Administrator may, but is not required to, review additional information from third-party sources in making this determination.

vi. All charges must be billed by a provider in accordance with generally accepted industry standards.

5. Provider Agreements. Where appropriate, and a willing appropriate provider acceptable to the Plan member is available, the Plan Administrator may enter into an agreement establishing the rates payable for outpatient dialysis goods and/or services with the provider, provided that such agreement must identify this Section of the Plan and clearly state that such agreement is intended to supersede this Section.

6. Discretion. The Plan Administrator shall have full authority and discretion to interpret, administer and apply this Section, to the greatest extent permitted by law;

13. **Durable Medical Equipment.** Charges for rental, up to the purchase price, of Durable Medical Equipment, including glucose home monitors for insulin-Dependent diabetics. At its option, and with its advance written approval, the Plan may cover the purchase of such items when it is less costly and more practical than rental. The Plan does not pay for:

a. Any purchases without its advance written approval;

b. Replacements or repairs; or
c. The rental or purchase of items which do not fully meet the definition of "Durable Medical Equipment";

14. **Foot Disorders.** Surgical treatment of foot disorders, including associated services, performed by a licensed podiatrist (excluding routine foot care);

15. **Glaucoma.** Treatment of glaucoma, cataract Surgery and one set of lenses (contacts or frame-type);

16. **Home Health Care.** Charges by a Home Health Care Agency:

a. Registered Nurses or Licensed Practical Nurses;
b. Certified home health aides under the direct supervision of a Registered Nurse;
c. Registered therapist performing physical, occupational or Speech Therapy;
d. Physician calls in the office, home, clinic or Outpatient department;
e. Services, drugs and medical supplies which are Medically Necessary for the treatment of the Plan Participant that would have been provided in the Hospital, but not including Custodial Care; and
f. Rental of Durable Medical Equipment or the purchase of this equipment if economically justified, whichever is less.

NOTE: Transportation services are not covered under this benefit;

17. **Hospice Care.** Charges relating to Hospice Care, provided the Plan Participant has a life expectancy of 6 months or less, subject to the maximums, if any, stated in the Summary of Benefits. Covered Hospice expenses are limited to:

a. Room and Board for Confinement in a Hospice;
b. Ancillary charges furnished by the Hospice while the patient is confined therein, including rental of Durable Medical Equipment which is used solely for treating an Injury or Sickness;
c. Medical supplies, drugs and medicines prescribed by the attending Physician, but only to the extent such items are necessary for pain control and management of the terminal condition;
d. Physician services and nursing care by a Registered Nurse, Licensed Practical Nurse or a Licensed Vocational Nurse (L.V.N.);
e. Home health aide services;
f. Home care furnished by a Hospital or Home Health Care Agency, under the direction of a Hospice, including Custodial Care if it is provided during a regular visit by a Registered Nurse, a Licensed Practical Nurse or a home health aide;
g. Medical social services by licensed or trained social workers, Psychologists or counselors;
h. Nutrition services provided by a licensed dietitian; and
i. Bereavement counseling, which is a supportive service provided by the Hospice team to Plan Participants in the deceased's Family after the death of the Terminally Ill person, to assist the Plan Participants in adjusting to the death. Benefits will be payable if the following requirements are met:
    (1) On the date immediately before his or her death, the Terminally Ill person was in a Hospice Care Program and a Plan Participant under the Plan; and
    (2) Charges for such services are Incurred by the Plan Participants within 6 months of the Terminally Ill person's death.

The Hospice Care Program must be renewed in writing by the attending Physician every 30 days. Hospice Care ceases if the terminal Illness enters remission;

18. **Hospital.** Charges made by a Hospital for:

a. Inpatient Treatment

(1) Daily Semi-Private Room and Board charges;

(2) Intensive Care Unit (ICU) and Cardiac Care Unit (CCU) Room and Board charges;
(3) General nursing services; and
(4) Medically Necessary services and supplies furnished by the Hospital, other than Room and Board

b. Outpatient Treatment

(1) Emergency room;
(2) Treatment for chronic conditions;
(3) Physical Therapy treatments;
(4) Hemodialysis; and
(5) X-ray, laboratory and linear therapy;

19. **Impregnation and Infertility Treatment.** Following charges related to Impregnation and Infertility Treatment: initial diagnosis; artificial insemination; fertility drugs; G.I.F.T. (Gamete Intrafallopian Transfer); Z.I.F.T. (Zygote Intrafallopian Transfer); and in-vitro fertilization. Benefits for in-vitro fertilization, G.I.F.T. and Z.I.F.T. are covered only when:

a. The Participant has been unable to attain or sustain a successful pregnancy through reasonable, less costly, medically appropriate infertility treatment;
b. The Participant has not undergone 4 completed oocyte retrievals, except if a live birth followed a completed oocyte retrieval, 2 or more oocyte retrievals shall be covered. In no event will more than 6 oocyte retrievals be covered by this Plan.

20. **Mastectomy**. The Federal Women's Health and Cancer Rights Act, signed into law on October 21, 1998, contains coverage requirements for breast cancer patients who elect reconstruction in connection with a Mastectomy. The new Federal law requires group health plans that provide Mastectomy coverage to also cover breast reconstruction Surgery and prostheses following Mastectomy.

As required by law, you are being provided this notice to inform you about these provisions. The law mandates that individuals receiving benefits for a Medically Necessary Mastectomy will also receive coverage for:

a. Reconstruction of the breast on which the Mastectomy has been performed;
b. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
c. Prostheses and physical complications from all stages of Mastectomy, including lymphedamas;

in a manner determined in consultation with the attending Physician and the patient.

This coverage will be subject to the same annual Deductible and coinsurance provisions that currently apply to Mastectomy coverage, and will be provided in consultation with you and your attending Physician;

21. **Medical Supplies.** Dressings, casts, splints, trusses, braces and other Medically Necessary medical supplies, with the exception of dental braces or corrective shoes, but including syringes for diabetic and allergy diagnosis, and lancets and chemstrips for diabetics;

22. **Newborn Care.** Hospital and Physician nursery care for Newborns who are natural children of the Employee or spouse and properly enrolled in the Plan, as set forth below. Benefits will be provided under the child's coverage, and the child's own Deductible and coinsurance provisions will apply;

a. Hospital routine care for a Newborn during the child's initial Hospital Confinement at birth; and
b. The following Physician services for well-baby care during the Newborn's initial Hospital Confinement at birth:
    (1) The initial Newborn examination and a second examination performed prior to discharge from the Hospital; and
    (2) Circumcision.

NOTE: The Plan will cover Hospital and Physician nursery care for an ill Newborn as any other medical condition, provided the Newborn is properly enrolled in the Plan. These benefits are provided under the baby's coverage;

23. **Nursing Services.** Services of a Registered Nurse or Licensed Practical Nurse;

24. **Obesity Services**. Charges for bariatric surgery for treatment of morbid obesity when the following 3 criteria are met:

    a. A diagnosis of Morbid Obesity, defined as:
        1. A Body Mass Index (BMI) of greater than or equal to 40 kg/meter squared; or
        2. A BMI greater than or equal to 35 kg/meter squared with at least 2 of the following co-morbid conditions which have not responded to maximum medical management and which are generally expected to be reversed or improved by bariatric treatment: hypertension, dyslipidemia, diabetes mellitus, coronary heart disease, and/or sleep apnea.
    b. At least a 5 year history of Morbid Obesity supported by medical documentation.
    c. It is expected that appropriate non-surgical treatment should have been attempted prior to surgical treatment of obesity. The non-surgical treatment of Morbid Obesity appropriateness criteria includes:
        1) Medical record documentation of active participation in a clinically supervised, non-surgical program of weight reduction for at least 6 months, occurring within the twenty-four (24) months prior to the proposed surgery and preferably unaffiliated with the bariatric surgery program. Note: The initial BMI at the beginning of a weight reduction program will be the "qualifying" BMI used to meet the BMI criteria for the definition of morbid obesity.
        2) A program will be considered appropriate if it includes the following components:
            i. Nutrition therapy, which may include medical nutrition therapy as a very low calorie diet such as MediFast or OptiFast OR a recognized commercial diet-based weight loss program such as Weight Watchers, Jenny Craig, etc.
            ii. Behavior modification or behavioral health interventions.
            iii. Counseling and instruction on exercise and increased physical activity.
            iv. Pharmacologic therapy (as appropriate).
            v. Ongoing support for lifestyle changes to make and maintain appropriate choices that will reduce health risk factors and improve overall health.

    To be eligible for surgical treatment of Morbid Obesity, documentation of the following requirements must be met:
    a. Documentation that growth is completed. (Generally, growth is considered completed 18 years of age or with documentation of completed bone growth).
    b. Evaluation by a licensed professional counselor, psychologist or psychiatrist, should be completed within the 12 months preceding the request for surgery. This evaluation should document:
        1) The absence of significant psychopathology that would hinder the ability of an individual to understand the procedure and comply with medical/surgical recommendations.
        2) Any psychological co-morbidities that are contributing to weight mismanagement or a diagnosed eating disorder.
        3) Patient's willingness to comply with preoperative and postoperative treatment plans.

    A Participant may not be eligible for surgical treatment of Morbid Obesity if the following contraindications are present:
    a. Mental handicaps that render a patient unable to understand the rules of eating and exercise and therefore make them unable to participate effectively in the post-operative treatment program. An example is a patient with malignant hyperphagia (Prader-Willi syndrome), which combines mental retardation with an uncontrollable desire for food.
    b. Portal hypertension, which is an excessive hazard when laparoscopic gastric bypass surgery is performed.

c. Age greater than 65 because for these patients the weight loss is less effective, the duration of benefits is shorter and the risks of the procedures are greater.

25. **Occupational Therapy.** Treatment or services rendered by a registered occupational therapist, under the direct supervision of a Physician, in a home setting or at a facility or institution whose primary purpose is to provide medical care for an Illness or Injury, or at a free-standing Outpatient facility;

26. **Oral Surgery.** Oral Surgery in relation to the bone, including tumors, cysts and growths, not related to the teeth and extraction of soft tissue impacted teeth by a Physician or Dentist;

27. **Osseous Surgery.** Charges for osseous Surgery;

28. **Pathology Services.** Charges for Pathology Services;

29. **Physical Therapy.** Treatment or services rendered by a physical therapist, under direct supervision of a Physician, in a home setting or a facility or institution whose primary purpose is to provide medical care for an Illness or Injury, or at a free-standing duly licensed Outpatient therapy facility;

30. **Physician Services.** Services of a Physician for Medically Necessary care, including office visits, home visits, Hospital Inpatient care, Hospital Outpatient visits and exams, clinic care and surgical opinion consultations;

31. **Pregnancy Expenses.** Dependent Children are eligible for coverage for any expenses in connection with Pregnancy.

    Under the Newborns' and Mothers' Health Protection Act of 1996, group health plans and health insurance issuers generally may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn Child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a Provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). In no event will an "attending provider" include a plan, hospital, managed care organization, or other issuer.

    Benefits are payable in the same manner as for medical or Surgical care of an Illness, shown in the "Summary of Benefits" and this section, and subject to the same maximums;

32. **Preventive Care.** Charges for Preventive Care services.
    Benefits mandated through the ACA legislation include Preventive Care such as immunizations, screenings, and other services that are listed as recommended by the United States Preventive Services Task Force (USPSTF), the Health Resources and Services Administration (HRSA), and the Federal Centers for Disease Control (CDC).

    See http://www.uspreventiveservicestaskforce.org or https://www.healthcare.gov/preventive-care-benefits/ for more details.

    Important Note: The Preventive Care services identified through this link are recommended services, not mandated services. It is up to the Provider and/or Physician of care to determine which services to provide; the Plan Administrator has the authority to determine which services will be covered;

    Preventive and Wellness Services for Adults and Children – In compliance with section (2713) of the Affordable Care Act, benefits are available for evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF).

Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention with respect to the individual involved. With respect to infants, Children, and adolescents, evidence-informed Preventive Care and screenings as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA).

A description of Preventive and Wellness Services can be found at: https://www.healthcare.gov/preventive-care-benefits/.

Women's Preventive Services – With respect to women, such additional Preventive Care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration not otherwise addressed by the recommendations of the United States Preventive Service Task Force, which will be commonly known as HRSA's Women's Preventive Services Required Health Plan Coverage Guidelines. The HRSA has added the following eight categories of women's services to the list of mandatory preventive services:

a. Well-woman visits;
b. Gestational diabetes screening;
c. HPV DNA testing;
d. Sexually transmitted infection counseling;
e. HIV screening and counseling;
f. FDA-approved contraception methods and contraceptive counseling;
g. Breastfeeding support, supplies and counseling; and
h. Domestic violence screening and counseling.

A description of Women's Preventive Services can be found at: http://www.hrsa.gov/womensguidelines/ or at https://www.healthcare.gov/preventive-care-benefits/.

For information about breastfeeding support and supplies, including breast pumps, please contact the customer service number on the back of the member ID card;

33. **Private Duty Nursing.** Private duty nursing (outpatient only);

34. **Prosthetics, Orthotics, Supplies and Surgical Dressings.** Prosthetic devices (other than dental) to replace all or part of an absent body organ or part, including replacement due to natural growth or pathological change, but not including charges for repair or maintenance. Orthotic devices, but excluding orthopedic shoes and other supportive devices for the feet;

35. **Radiation Therapy.** Charges for radiation and dialysis therapy and treatment;

36. **Respiration Therapy.** Respiration therapy services, when rendered in accordance with a Physician's written treatment plan;

37. **Routine Patient Costs for Participation in an Approved Clinical Trial.** Charges for any Medically Necessary services, for which benefits are provided by the Plan, when a Participant in participating in a phase I, II, III or IV clinical trial, conducted in relation to the prevention, detection or treatment of a life-threatening Disease or condition, provided:

    a. The clinical trial is approved by:
        i. The Centers for Disease Control and Prevention of the U.S. Department of Health and Human Services;
        ii. The National Institute of Health;
        iii. The U.S. Food and Drug Administration;
        iv. The U.S. Department of Defense;

v. The U.S. Department of Veterans Affairs; or
vi. An Institutional review board of an Institution in Missouri that has an agreement with the Office for Human Research Protections in the U.S. Department of Health and Human Services; and

b. The research Institution conducting the Approved Clinical Trial and each health professional providing routine patient care through the Institution, agree to accept reimbursement at the applicable Allowable Expense, as payment in full for routine patient care provided in connection with the Approved Clinical Trial.

Coverage will not be provided for:

a. The cost of an Investigational new drug or device that is not approved for any indication by the U.S. Food and Drug Administration, including a drug or device that is the subject of the Approved Clinical Trial;
b. The cost of a service that is not in a health care service, regardless of whether the service is required in connection with participation in an Approved Clinical Trial;
c. The cost of a service that is clearly inconsistent with wisely accepted and established standards of care for a particular Diagnosis;
d. A cost associated with managing an Approved Clinical Trial;
e. The cost of a health care service that is specifically excluded by the Plan; or
f. Services that are part of the subject matter of the Approved Clinical Trial and that are customarily paid for by the research Institution conducting the Approved Clinical Trial;

38. **Second Surgical Opinions.** Charges for second surgical opinions. Third surgical opinions will be covered if second opinion does not agree with the first. Expenses associated with the following are not included: surgical procedures which are not covered under the Plan; minor surgical procedures that are routinely performed in a Physician's office, such as incision and drainage of an abscess or excision of benign lesions; an opinion obtained more than 3 months after a surgeon first recommended the elective surgical procedure;

39. **Skilled Nursing Facility.** Charges made by a Skilled Nursing Facility or a Convalescent Care Facility, up to the limits set forth in the Summary of Benefits, in connection with convalescence from an Illness or Injury (excluding drug addiction, chronic brain syndrome, alcoholism, senility, mental retardation or other Mental or Nervous Disorders) for which the Plan Participant is confined;

40. **Speech Therapy.** Speech therapy by a Physician or qualified speech therapist, when needed due to a Sickness or Injury (other than a functional nervous disorder) or due to surgery performed as the result of a Sickness or Injury, excluding Speech Therapy services that are educational in any part or due to articulation disorders, tongue thrust, stuttering, lisping, abnormal speech development, changing an accent, dyslexia, hearing loss which is not medically documented or similar disorders;

41. **Sterilization**. All FDA approved charges related to sterilization procedures, to the extent required by the Affordable Care Act (ACA);

42. **Surgery.** Surgical operations and procedures, unless otherwise specifically excluded under the Plan, and limited as follows:

a. Multiple procedures adding significant time or complexity will be allowed at:

(1) 100% of the full Usual and Customary Fee value for the first or major procedure;
(2) 50% of the Usual and Customary Fee value for the secondary and subsequent procedures;

b. Bilateral procedures which add significant time or complexity, which are provided at the same operative session, will be allowed at 100% of Usual and Customary Fee value for the major procedure, and 50% of the Usual and Customary Fee value for the secondary or lesser procedure;

c. Charges made for services rendered by an assistant surgeon will be allowed at 25% of the Usual, and Customary Fee value for the type of surgery performed;

d. No benefit will be payable for incidental procedures, such as appendectomy during an abdominal Surgery, performed during a single operative session;

43. **Surgical Treatment of Jaw.** Surgical treatment of Diseases, Injuries, fractures and dislocations of the jaw by a Physician or Dentist;

44. **Temporomandibular Joint Disorder.** Charges for the diagnosis and treatment of, or in connection with, temporomandibular joint disorders, myofacial pain dysfunction or orthognathic treatment; and

45. **Transplants.** Organ or tissue transplants are covered for the following human to human organ or tissue transplant procedures:

    a. Bone marrow;
    b. Heart;
    c. Lung;
    d. Heart and lung;
    e. Liver;
    f. Pancreas;
    g. Kidney; and
    h. Cornea.

    In addition, the Plan will cover any other transplant that is not Experimental.

    Covered expenses will be considered the same as any other Sickness for Employees or Dependents as a recipient of an organ or tissue transplant. Covered expenses include:

    a. Organ or tissue procurement from a cadaver consisting of removing, preserving and transporting the donated part;
    b. Services and supplies furnished by a Provider; and
    c. Drug therapy treatment to prevent rejection of the transplanted organ or tissue.

15.02 Psychiatric and Substance Abuse Benefits

The Plan will provide benefits for intermediate levels of care for mental health conditions and substance abuse disorders in parity with medical or surgical care of the same level. For instance, if the Plan provides benefits for a skilled nursing or rehabilitation facility for medical or surgical treatment, the Plan will provide equal benefits for intensive outpatient therapy or partial hospitalization. Contact the customer service number on the back of the member ID card for more information.

15.02A Inpatient Benefits

Subject to the limitations contained in the Summary of Benefits, the Plan will pay covered expenses for:

1. Semi-private hospital Room and Board;
2. Miscellaneous facility charges on days a Room and Board charge is covered;
3. Individual psychotherapy;
4. Group psychotherapy;
5. Psychological testing;
6. Family counseling; and
7. Convulsive therapy treatment.

The benefits above are also available when receiving treatment during the day only or during the night only at a day/night Psychiatric Hospital or at a Substance Abuse Treatment Center and/or Rehabilitation Hospital.

15.02B Outpatient Benefits
Subject to the limitations contained in the Summary of Benefits, the Plan will pay covered expenses for:

1. Individual psychotherapy;
2. Group psychotherapy;
3. Psychological testing;
4. Family counseling;
5. Convulsive therapy treatment; and
6. Prescription drugs or medicines for the treatment of mental illness or chemical dependency.

15.03 Exclusions
Some health care services are not covered by the Plan. In addition to the General Exclusions set forth in Article VII, these include, but are not limited to, any charge for care, supplies, or services, which are:

1. **Abortion.** Expenses incurred directly or indirectly as the result of an abortion, except when the pregnancy is the result of rape or incest or the mother's life is endangered;

2. **Acupuncture.** Charges relating directly or indirectly to acupuncture;

3. **Biofeedback.** Biofeedback;

4. **Consultations.** Consultations, charges for failure to keep a scheduled visit, or charges for completion of a claim form;

5. **Cosmetic Surgery.** Charges for Cosmetic Surgery;

6. **Custodial Care.** Custodial Care, domiciliary care or rest cures, or home health care except as specifically provided herein;

7. **Education or Training Program.** Services performed by a Physician or other Provider enrolled in an education or training program when such services are related to the education or training program, except as specifically provided herein;

8. **Eye Refractions.** Eye refractions, eyeglasses, contact lenses, or the vision examination for prescribing or fitting eyeglasses or contact lenses (except for aphakic patients, and soft lenses or sclera shells intended for use in the treatment of Disease or Injury);

9. **Glaucoma.** Treatment of glaucoma, cataract Surgery and one set of lenses (contacts or frame-type);

10. **Genetic Testing**. Expenses related to Genetic Testing performed as a diagnostic tool; to predict the presence of a specific disease in those with familial history, preconception or prenatal screening; or population screening;

11. **Hair Pieces.** Wigs, artificial hair pieces, human or artificial hair transplants, or any drug, prescription or otherwise, used to eliminate baldness;

12. **Hearing Devices**. Hearing aids or examinations for the prescription or fitting of hearing aids;

13. **Hypnosis.** Expenses related to the use of hypnosis;

14. **Oral Surgery.** Oral Surgery or dental treatment, except as specifically provided in the Plan;

15. **Organ Transplants.** Expenses related to donation of a human organ or tissue, except as specifically provided;

16. **Orthopedic Shoes.** Orthopedic shoes, unless they are an integral part of a leg brace and the cost is included in the orthotist's charge, and other supportive devices for the feet;

17. **Personal Convenience Items.** Equipment that does not meet the definition of Durable Medical Equipment, including air conditioners, humidifiers and exercise equipment, whether or not recommended by a Physician;

18. **Radial Keratotomy**. Radial keratotomy or other plastic surgeries on the cornea in lieu of eyeglasses;

19. **Routine Physical Examinations.** Routine or periodic physical examinations, related x-ray and laboratory expenses, and nutritional supplements, except as provided in the Summary of Benefits;

20. **Sex Change Operation.** Expenses related to a sex change operation or treatment of sexual dysfunction not related to organic disease;

21. **Travel.** Travel, whether or not recommended by a Physician, except as specifically provided herein; and

22. **Vitamins.** Vitamins.

15.04 Cost Containment

15.04A Pre-Certification Procedures
The Inpatient Utilization Management Service is simple and easy for Participants to use. Whenever a Participant is advised that Inpatient Hospital care is needed, it is the Participant's responsibility to call the pre-certification department at its toll-free number, which is 1-877-284-0102. The review process will continue, as outlined below, until the Participant is discharged from the Hospital. **Pre-certification is not required for Inpatient admission to skilled nursing facilities, convalescent or rehabilitation facilities unless otherwise stated in this document.**

Urgent Care or Emergency Admissions:
If a Participant needs medical care for a condition which could seriously jeopardize his or her life, obtain such care without delay, and communicate with the Plan as soon as reasonably possible.

If a Participant must be admitted on an Emergency basis, the Participant should follow the Physician's instructions carefully and contact the pre-certification department as follows:

1. For Emergency admissions after business hours on Friday, on a weekend or over a holiday weekend, a call to the pre-certification department must be made within 72 hours after the admission date, but no later than the first business day following the Emergency admission, by or on behalf of the covered patient; and
2. For Emergency admissions on a weekday, a call to the pre-certification department must be made within 24 hours after the admission date.

The Plan does not require the Participant to obtain approval of a medical service prior to getting treatment for an urgent care or emergency situation, so there are no "Pre-service Urgent Care Claims" under the Plan. The Participant simply follows the Plan's procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a Post-service Claim.

Non-emergency Admissions:
For Inpatient Hospital stays that are scheduled in advance, a call to the pre-certification department should be completed as soon as possible before actual services are rendered. Once the pre-certification call is received, it will be routed to an appropriate review specialist who will create an on-line patient file. The review specialist will contact the Participant's attending Physician to obtain information and to discuss the specifics of the admission request. An on-line expert system that features state-of-the-art, widely accepted clinical review criteria is used to effectively guide the review process. If appropriate, alternative care will be explored with the Physician.

If, after assessing procedure necessity, the need for an Inpatient confinement is confirmed, the review specialist will determine the intensity of management required and will remain in contact with the Physician or Hospital during the confinement.

If, at any time during the review process, Medical Necessity cannot be validated, the review specialist will refer the episode to a board-certified Physician advisor who will immediately contact the attending Physician to negotiate an appropriate treatment plan. At the end of the Hospital confinement, the review specialist is also available to assist with discharge planning and will work closely with the attending Physician and Hospital to ensure that medically appropriate arrangements are made.

Ambulance (air/flight) Services:
All flight-based inter-facility patient transport services require pre-certification from the Plan Administrator via Sentinel Air Medical Alliance, LLC. Please contact Sentinel Air Medical Alliance, LLC at (877) 542-8828.

Sentinel Air Medical Alliance, LLC may discuss with the Physician and/or Hospital/facility the Diagnosis and the need for inter-facility patient transport versus alternatives.

Failure to notify Sentinel Air Medical Alliance, LLC and subsequently obtain a pre-certification number from Sentinel Air Medical Alliance, LLC may, solely in the Plan Administrator's discretion, result in a reduction or denial of benefits for charges arising from or related to flight-based inter-facility patient transport. Non-compliance penalties imposed for failure to notify Sentinel Air Medical Alliance, LLC will not be included as part of the annual out of pocket maximum.

The Plan Administrator retains the discretionary authority to limit benefit availability to alternative Providers of inter-facility patient transport if and when a Provider fails to comply with the terms of the Plan, or proposed charges exceed the Maximum Allowable Charge in accordance with the terms of the Plan.

15.04B Pre-Certification Penalty
The program requires the support and cooperation of each Participant. If a Participant follows the instructions and procedures, he or she will receive the normal Plan benefits for the services. However, if a Participant fails to notify pre-certification department of any Inpatient Hospital stay as required in the section entitled "Pre-Certification Procedures," allowed charges will be reduced by $250 for Room and Board, Hospital miscellaneous services, and any other charges related to that confinement which are billed by the Hospital. The Participant will be responsible for payment of the part of the charge that is not paid by the Plan.

15.04C Alternate Course of Treatment
Certain types of conditions, such as spinal cord Injuries, cancer, AIDS or premature births, may require long-term, or perhaps lifetime, care. The claims selected will be evaluated as to present course of treatment and alternate care possibilities.

If the Plan Administrator should determine that an alternate, less expensive, course of treatment is appropriate, and if the attending Physician agrees to the alternate course of treatment, all Medically Necessary expenses stated in the treatment plan will be eligible for payment under the Plan, subject to the applicable lifetime benefit set forth in this Plan, even if these expenses normally would not be eligible for payment under the Plan. In the event the Participant and the attending Physician select a more expensive course of treatment, coverage under the Plan will be based upon the charge allowed for the alternate, less expensive, course of treatment.

15.04D Oncology Program
This provision describes a specialty case management program designed for certain aspects of care received by cancer patients who are beneficiaries under the Plan.

Your Plan has entered into an arrangement with American Health Holding, a company specializing in oncology case management, to assist you and your oncologist during the course of cancer treatment when administered either in an outpatient setting (e.g., in the physician's office or other covered outpatient setting) or an inpatient setting. The

program applies to the plan of treatment for all cancer types and stages and begins with a treatment planning phase (including drug and/or radiation treatment) and continues through active treatment and transitional care.

A Registered Nurse will be assigned to you and will contact you to provide support, education, and answer any questions you might have about your disease and your treatment plan and will remain in contact with you and your oncologist for the duration of your cancer journey.

Unless your oncologist has entered into an agreement with HealthSCOPE Benefits to accept other reimbursement rates, the payment for all drugs used in the treatment of cancer will be limited to the rate of Average Sales Price plus 10%. Average Sales Price is the price calculated by pharmaceutical manufacturers and submitted to the Centers for Medicare and Medicaid Services (CMS) on a quarterly basis.

ARTICLE XVI
DENTAL BENEFITS

Employees only are eligible for Dental coverage after 5 years of employment with the Participating Employer. Dependent Spouses are children are not eligible.

Maximum benefit per calendar year for Class 1, 2 and 3 Services	$200

Covered Dental Expenses:	Benefits
Class 1 Services (Preventive Care)	80%
Class 2 Services (Repair and Restoration)	80%
Class 3 Services (Major Dental Repair)	80%
Charges are limited to Usual and Customary Fees.	

16.01 Covered Expenses

The following is a brief description of the types of expenses that will be considered for coverage under the Plan, subject to the limitations contained in the Summary of Benefits. Charges must be for services and supplies customarily employed for treatment of the dental condition, and rendered in accordance with ADA accepted standards of practice. Coverage will be limited to Usual and Customary Fees.

Class 1 Services (Preventive Care)

1. Routine oral examinations and prophylaxis (cleaning, scaling and polishing teeth), but not more than once each in any period of 6 consecutive months;
2. Full mouth x-rays, but not more than once in any period of 6 consecutive months;
3. Panoramic x-rays, but not more than once in any period of 12 consecutive months;
4. Periapical x-rays, as required, and bitewing x-rays once in any period of 6 consecutive months; and
5. Topical application of fluoride for Dependent Children, but not more than once in any period of 6 consecutive months; and

Class 2 Services (Repair and Restoration)

1. Palliative Emergency treatment of an acute condition requiring immediate care.
2. All Medically Necessary x-rays;
3. Amalgam, silicate, acrylic, synthetic porcelain and composite filling restorations to restore diseased or accidentally broken teeth. Gold foil restorations are not eligible;
4. Simple extractions;
5. Endodontics, including pulpotomy, direct pulp capping and root canal treatment;
6. Anesthetic services, except local infiltration or block anesthetics, performed by, or under the direct personal supervision of, and billed for by a Dentist, other than the operating Dentist or his or her assistant;
7. Periodontal examinations, treatment and surgery; and
8. Consultations.

Class 3 Services (Major Dental Repair)

Prosthodontic services (initial installation or replacement of bridgework or dentures) will be covered only when a Participant has been covered continuously for at least 12 months, unless otherwise required by applicable law.

1. Inlays, gold fillings, crowns, and initial installation of full or partial dentures or fixed bridgework to replace one or more natural teeth;
2. Repair or recementing of crowns, inlays, bridgework or dentures and relining of dentures once in any period of 12 consecutive months;

3. Unless otherwise required by applicable law, replacement of an existing denture or fixed bridgework, or the addition of teeth to an existing partial removable denture or bridgework, to replace one or more natural teeth:
    a. Where the existing denture or bridgework was installed at least five years prior to its replacement and it cannot be made serviceable; or
    b. Where the existing denture is an immediate temporary denture, and necessary replacement by the permanent denture takes place within 12 months;
4. Periodontal scaling;
5. Oral Surgery;
6. Re-lines;
7. Post and core; and
8. Stainless steel crowns.

16.02 Exclusions and Limitations

The following exclusions and limitations are in addition to those set forth in the Articles entitled "General Limitations and Exclusions," and "Summary of Benefits."

1. **Adjustments**. Charges for services to alter vertical dimension (work done or appliance used to increase the distance between nose and chin); to restore or maintain occlusion (work done or appliance used to change the way the top and bottom teeth meet or mesh); to replace tooth structure lost as a result of abrasion or attrition; for splinting; or for treatment of disturbances of the temporomandibular joint;

2. **Administrative Costs**. For administrative costs of completing claim forms or reports or for providing dental records;

3. **After the Termination Date.** The Plan will not pay for services or supplies furnished after the date coverage terminates, even if payments have been predetermined for a course of treatment submitted before the termination date. However, benefits for covered dental expenses incurred for the following procedures will be payable as though the coverage had continued in force:

    a. A prosthetic device, such as full or partial dentures, if the Dentist took the impression and prepared the abutment teeth while the patient was a Participant in the Plan, and delivers and installs the device within two months following termination of coverage;
    b. A crown, if the Dentist prepared the tooth for the crown while the patient was a Participant in the Plan, and installs the crown within two months following termination of coverage; and
    c. Root canal therapy if the Dentist opened the tooth while the patient was a Participant in the Plan, and completes the treatment within two months following termination of coverage;

4. **Broken Appointments.** For charges for broken or missed dental appointments;

5. **Cosmetic**. Charges for cosmetic dental work. This includes, but is not limited to, characterization of dentures and services to correct congenital or developmental malformations. This exclusion will not apply to cosmetic work needed as a result of Accidental Injuries, but damage resulting from biting or chewing is not considered an Accidental Injury. This exclusion also does not apply to covered Orthodontic Treatment;

6. **Crowns.** For crowns for teeth that are restorable by other means or for the purpose of Periodontal Splinting;

7. **Education**. Charges for instruction in oral hygiene, plaque control or diet;

8. **Excess Charges**. Charges in excess of the Reasonable Charge for the service or supply received or charges in excess of any maximum payable under this Plan;

9. **Experimental**. Charges for Experimental dental care, implantology or dental care which is not customarily used or which does not meet the standards set by the American Dental Association;

10. **Government Provided**. Charges for dental care paid for or provided by the laws of any government or treatment given in a government-owned facility, unless the Employee or Dependent is legally required to pay;

11. **Hygiene.** For oral hygiene, plaque control programs or dietary instructions;

12. **Immediate Relative**. Services rendered by a person who is an immediate relative of, or who ordinarily resides with, the Plan Participant requiring treatment. "Immediate relative" means spouse, child, brother, sister or parent of the Plan Participant, whether by birth, adoption or marriage;

13. **Implants.** For implants, including any appliances and/or crowns and the surgical insertion or removal of implants except, first-time non-cosmetic dental implants;

14. **Late Enrollee**. Charges for crowns, bridgework, dentures, periodontics and orthodontics incurred during the first 24 months of coverage for a late enrollee, unless such services and supplies are needed as a result of Accidental Injury sustained by the Plan Participant. (Damage resulting from biting or chewing is not considered an Accidental Injury.) "Late enrollee" means a person who enrolls for coverage during an annual enrollment period because he or she failed to enroll when first eligible for coverage or during a special enrollment period;

15. **Miscellaneous.** The Plan does not cover any charge, service or supply which is:

    a. For treatment other than by a Dentist or Physician, except:
        (1) Cleaning, scaling and application of fluoride performed by a licensed dental hygienist under the supervision of a Dentist; and
        (2) Non-experimental services performed at a dental school under the supervision of a Dentist, if the school customarily charges patients for its services;
    b. For local infiltration anesthetic when billed for separately by a Dentist;
    c. For personalization or characterization of dentures or veneers or any cosmetic procedures or supplies;
    d. For oral hygiene or dietary instruction;
    e. For a plaque control program (a series of instructions on the care of the teeth);
    f. For implants, including any appliances and/or crowns and the surgical insertion or removal of implants;
    g. For periodontal splinting;
    h. For consultations, charges for failure to keep a scheduled visit, or charges for completion of a claim form;
    i. For substances or agents which are administered to minimize fear, or charges for analgesia, unless the patient is handicapped by cerebral palsy, mental retardation or spastic disorder;
    j. For replacement of a lost, missing or stolen prosthetic device;
    k. Not equal to accepted standards of dental practice, including charges for services or supplies which are Experimental;
    l. Paid, payable or required to be provided under any no-fault or equivalent automobile insurance law. Any uninsured motorist will be considered to be self-insured;
    m. Charges for missed appointments or completion of claim forms;
    n. Covered under the "Medical Benefits" Article of the Plan; and
    o. Services performed by a Physician or other Provider enrolled in an education or training program when such services are related to the education or training program, except as specifically provided herein;

16. **Missing Appliances**. Charges for replacement of lost, missing or stolen appliances or prosthetic devices;

17. **More Expensive Course of Treatment.** In all cases involving covered services in which the Provider and the Participant select a more expensive course of treatment than is customarily provided by the dental profession, consistent with sound professional standards of dental practice for the dental condition concerned, coverage under the Plan will be based upon the charge allowed for the lesser procedure;

18. **No Coverage**. Services or supplies for which charges are incurred at a time when no coverage is in force for that person, or for which charges are incurred while coverage is in force, but final delivery is made more than 3 months after the date coverage for that person terminated;

19. **No Legal Obligation**. Charges for which the person has no legal obligation to pay, or for which no charge would be made in the absence of a Treatment Plan;

20. **No Listing.** For services which are not included in the list of covered dental services;

21. **Not Necessary**. Charges for unnecessary care, treatment, services or supplies, including replacement at any time of a bridge or denture which meets or can be made to meet commonly held dental standards of functional acceptability;

22. **Not Recommended**. Charges for services or supplies which are not recommended and approved by a Dentist or Physician;

23. **Occupational**. Charges for dental care which results from any employment, if covered to any extent by worker's compensation or similar law;

24. **Orthognathic Surgery.** For surgery to correct malpositions in the bones of the jaw;

25. **Personalization**. For expenses for services or supplies that are cosmetic in nature, including charges for personalization or characterization of dentures;

26. **Replacements**. Charges for replacement made within five years after the last placement of any prosthetic appliance, crown, inlay or onlay restoration, or fixed bridge. This exclusion is waived if replacement is needed because the appliance, crown, inlay, onlay or bridge, while in the oral cavity, is damaged beyond repair due to Injury sustained by the Plan Participant. (Damage resulting from biting or chewing is not considered an Accidental Injury;)

27. **Self-Inflicted**. Charges for care, treatment, services and supplies needed as a result of intentionally self-inflicted Injury or Sickness;

28. **Single Provider Care.** In the event a Participant transfers from the care of one Provider to that of another during a course of treatment, or if more than one Provider performs services for one or more dental procedures, the Plan shall consider only such expense as would be appropriate had a single Provider performed the service. An appropriate expense in this case will be the Usual and Customary Fee;

29. **Splinting.** For crowns, fillings or appliances that are used to connect (splint) teeth, or change or alter the way the teeth meet, including altering the vertical dimension, restoring the bite (occlusion) or are cosmetic; and

30. **War/Riot**. Charges for services or supplies needed as a result of war, declared or undeclared, or any act of war or act of aggression by any Country; or voluntary participation in a riot.

ARTICLE XVII
PRESCRIPTION DRUG BENEFITS

Covered Prescription Drug Expenses:	Participating Pharmacy
Pharmacy Option:	
Copayment, per prescription or refill, for generic	20% coinsurance $5 minimum, $25 maximum
Copayment, per prescription or refill, for formulary name brands	20% coinsurance $25 minimum, $50 maximum
Copayment, per prescription or refill, for non-formulary name brands	20% coinsurance $40 minimum, $75 maximum
Mail Order Option:	
Copayment, per prescription or refill, for generic	20% coinsurance $15 minimum, $75 maximum
Copayment, per prescription or refill, for formulary name brands	20% coinsurance $65 minimum, $130 maximum
Copayment, per prescription or refill, for non-formulary name brands	20% coinsurance $100 minimum, $175 maximum
Specialty Drugs (30-day supply): Copayment, per prescription or refill	$100 copay

Participating pharmacies ("Participating Pharmacies") have contracted with the Plan to charge Participants reduced fees for covered Drugs. LDI is the administrator of the prescription drug plan. Participants will be issued an identification card to use at the pharmacy at time of purchase. Participants will be held fully responsible for the consequences of any pharmacy identification card after termination of coverage. **No reimbursement will be made when a Drug is purchased from a non-Participating Pharmacy or when the identification card is not used.**

The Mail Order Option is available for maintenance medications (those that are taken for long periods of time, such as Drugs sometimes prescribed for heart disease, high blood pressure, asthma, etc.). Because of the volume buying, LDI, the mail order pharmacy, is able to offer Participants significant savings on their prescriptions.

The copayment is applied to each charge and is shown on the Summary of Benefits, above. The copayment amount is not counted toward any out-of-pocket maximums under the Plan.

17.01 Covered Expenses

The following are covered under the Plan:

1. **Acne Control and Cosmetic Anti-Aging.** Accutane and Retin A;
2. **Andro Gels.** Charges for andro gels with prior authorization after generic has been prescribed;
3. **Bee Sting Kits.** Charges for EPI PEN and Ana-Kit;
4. **Blood and Blood Plasma.** Charges for Blood and Blood Plasma;
5. **Compounded Prescriptions.** All compounded prescriptions containing at least one prescription ingredient in a therapeutic quantity, with prior authorization;

6. **Contraceptives.** All FDA approved contraceptives Drugs and methods, in accordance with HRSA guidelines;

7. **DESI Drugs.** Charges for DESI Drugs;

8. **Diabetes**. Insulins, insulin syringes and needs, diabetic supplies – legend diabetic supplies – over-the-counter, and glucose test strips, when prescribed by a Physician. Certain diabetic medications will require prior authorization;

9. **Fertility Agents.** Charges for fertility agents;

10. **Gleevec.** Gleevec, for treatment of any of the following conditions:

    a. CML myeloid blast crisis;
    b. CML accelerated phase; or
    c. CML in chronic phase after failure of interferon treatment;

    Prior authorization is required. In order to obtain such authorization, information from the patients' Physician indicating the condition being treated must be submitted to the Plan.

11. **Glucose Meters**. Charges for glucose meters;

12. **Imitrex Injection.** Charges for Imitrex injections (migrane auto-injector);

13. **Immunizations.** Immunization agents or biological sera;

14. **Immunologicals.** Charges for Immunologicals (vaccines);

15. **Impotency.** A charge for impotency medication, including Viagra™;

16. **Injectables.** A charge for injectables;

17. **Legend Drugs.**

    a. Diabetic supplies;
    b. Legend Drugs with over-the-counter equivalents;
    c. Vitamins; and
    d. Pre-natal vitamins;

18. **Over-the-Counter (OTC) Drugs.** OTC Drugs related to Preventive and Wellness Services as specified by the Affordable Care Act of 2010. A description of these services can be found at: https://www.healthcare.gov/preventive-care-benefits/.

    This includes FDA-approved generic Drugs and Over-the-Counter (OTC) Drugs, devices and supplies related to Women's Preventive Services, as specified by the Affordable Care Act of 2010.

    A description of FDA-approved contraceptive methods can be found at: http://www.fda.gov/ForConsumers/ByAudience/ForWomen/WomensHealthTopics/ucm117971.htm;

19. **Required by Law.** All Drugs prescribed by a Physician that require a prescription either by Federal or State law, except injectables (other than insulin) and the Drugs excluded below;

20. **Smoking Deterrents.** A charge for Drugs or aids for smoking cessation, including, but not limited to, nicotine gum and smoking cessation patches; and

21. **Specialty Drugs**. Charges for specialty drugs obtained through LDI with prior authorization, limited to 30-day supply;

22. **Vaccinations**. Charges for flu, shingles and pneumonia shots;

23. **Vitamins.** Vitamins.

17.02 Limitations

The benefits set forth in this Article will be limited to:

1. **Dosages.**
   a. With respect to the Pharmacy Option, any one prescription is limited to a 34-day supply; and
   b. With respect to the Mail Order Option, any one prescription is limited to the greater of a 91-day supply.

2. **Refills.**
   a. Refills only up to the number of times specified by a Physician; and
   b. Refills up to one year from the date of order by a Physician.

17.03 Exclusions

In addition to the General Exclusions set forth in Article VII, the following are not covered by the Plan:

1. **Administration.** Any charge for the administration of a covered Drug;

2. **Allergy Sera.** Charges for allergy sera;

3. **Anorexiants.** Anorexiants (weight-loss drugs);

4. **Consumed Where Dispensed.** Any Drug or medicine that is consumed or administered at the place where it is dispensed;

5. **Devices.** Devices of any type, even though such devices may require a prescription, including, but not limited to, therapeutic devices, artificial appliances, braces, support garments or any similar device;

6. **Excluded Items.** Any charge excluded under the Articles entitled "General Limitations and Exclusions," or "Summary of Benefits";

7. **Experimental Drugs.** Experimental Drugs and medicines, even though a charge is made to the Participant;

8. **Growth Hormones.** Charges for growth hormones;

9. **Institutional Medication.** A Drug or medicine that is to be taken by a Participant, in whole or in part, while confined in an Institution, including any Institution that has a facility for dispensing Drugs and medicines on its premises;

10. **Investigational Use Drugs.** A Drug or medicine labeled "Caution – limited by Federal law to investigational use;"

11. **Medical Devices and Supplies.** Charges for legend and over-the-counter medical devices and supplies;

12. **No Charge.** A charge for Drugs which may be properly received without charge under local, State or Federal programs;

13. **Non-Insulin Syringes/Needles.** Charges for non-insulin syringes and needles;

14. **Non-Prescription Drug or Medicine.** A Drug or medicine that can legally be bought without a prescription, except for injectable insulin;

15. **Over-the-Counter Drugs.** Charges for over-the-counter drugs, except as required herein;

16. **Occupational.** Prescriptions necessitated due to an occupational activity or event occurring as a result of an activity for wage or profit;

17. **Rogaine.** Charges for Rogaine (topical minoxidil); and

18. **Steroids.** Anabolic steroids.

ARTICLE XVIII
HIPAA PRIVACY

Commitment to Protecting Health Information

The Plan will comply with the Standards for Privacy of Individually Identifiable Health Information (i.e., the "Privacy Rule") set forth by the U.S. Department of Health and Human Services ("HHS") pursuant to the Health Insurance Portability and Accountability Act ("HIPAA"). Such standards control the dissemination of "protected health information" ("PHI") of Plan Participants. Privacy standards will be implemented and enforced in the offices of the Employer and Plan Sponsor and any other entity that may assist in the operation of the Plan.

The Plan is required by law to take reasonable steps to ensure the privacy of the Plan Participant's PHI, and inform him/her about:

1. The Plan's disclosures and uses of PHI;
2. The Plan Participant's privacy rights with respect to his/her PHI;
3. The Plan's duties with respect to his/her PHI;
4. The Plan Participant's right to file a complaint with the Plan and with the Secretary of HHS; and
5. The person or office to contact for further information about the Plan's privacy practices.

Within this provision capitalized terms may be used, but not otherwise defined. These terms shall have the same meaning as those terms set forth in 45 CFR Sections 160.103 and 164.501. Any HIPAA regulation modifications altering a defined HIPAA term or regulatory citation shall be deemed incorporated into this provision.

How Health Information May be Used and Disclosed

In general, the Privacy Rules permit the Plan to use and disclose an individual's PHI, without obtaining authorization, only if the use or disclosure is:

1. To carry out Payment of benefits;
2. For Health Care Operations;
3. For Treatment purposes; or
4. If the use or disclosure falls within one of the limited circumstances described in the rules (e.g., the disclosure is required by law or for public health activities).

Disclosure of PHI to the Plan Sponsor for Plan Administration Purposes

In order that the Plan Sponsor may receive and use PHI for plan administration purposes, the Plan Sponsor agrees to:

1. Not use or further disclose PHI other than as permitted or required by the Plan documents or as required by law (as defined in the privacy standards);

2. Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan, agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;

3. Establish safeguards for information, including security systems for data processing and storage;

4. Maintain the confidentiality of all PHI, unless an individual gives specific consent or authorization to disclose such data or unless the data is used for health care payment or Plan operations;

5. Receive PHI, in the absence of an individual's express authorization, only to carry out Plan administration functions;

6. Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the privacy standards;

7. Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;

8. Make available PHI in accordance with section 164.524 of the privacy standards (45 CFR 164.524);

9. Make available PHI for amendment and incorporate any amendments to PHI in accordance with section 164.526 of the privacy standards (45 CFR 164.526);

10. Make available the information required to provide an accounting of disclosures in accordance with section 164.528 of the privacy standards (45 CFR 164.528);

11. Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services ("HHS"), or any other officer or employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with part 164, subpart E, of the privacy standards (45 CFR 164.500 et seq);

12. Report to the Plan any inconsistent uses or disclosures of PHI of which the Plan Sponsor becomes aware;

13. Train employees in privacy protection requirements and appoint a privacy compliance coordinator responsible for such protections;

14. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and

15. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in section 164.504(f)(2)(iii) of the privacy standards (45 CFR 164.504(f)(2)(iii)), is established as follows:

    (a) The following employees, or classes of employees, or other persons under control of the Plan Sponsor, shall be given access to the PHI to be disclosed:

        (i) Privacy Officer: The access to and use of PHI by the individuals described above shall be restricted to the plan administration functions that the Plan Sponsor performs for the Plan.

    (b) In the event any of the individuals described in above do not comply with the provisions of the Plan documents relating to use and disclosure of PHI, the Plan Administrator shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. The Plan Administrator will promptly report such violation or non-compliance to the Plan, and will cooperate with the Plan to correct violation or non-compliance to impose appropriate disciplinary action or sanctions. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.

Disclosure of Summary Health Information to the Plan Sponsor

The Plan may disclose PHI to the Plan Sponsor of the group health plan for purposes of plan administration or pursuant to an authorization request signed by the Plan Participant. The Plan may use or disclose "summary health information" to the Plan Sponsor for obtaining premium bids or modifying, amending, or terminating the group health plan.

Disclosure of Certain Enrollment Information to the Plan Sponsor

Pursuant to section 164.504(f)(1)(iii) of the privacy standards (45 CFR 164.504(f)(1)(iii)), the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has un-enrolled from a health insurance issuer or health maintenance organization offered by the Plan to the Plan Sponsor.

Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage

The Plan Sponsor may hereby authorize and direct the Plan, through the Plan Administrator or the third party administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters ("MGUs") for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the privacy standards.

Other Disclosures and Uses of PHI:

Permissible Uses and Disclosures of PHI

1. Treatment, Payment and Health Care Operations: The Plan has the right to use and disclose a Plan Participant's PHI for all activities as included within the definitions of Treatment, Payment, and Health Care Operations and pursuant to the HIPAA Privacy Rule.

2. Business Associates: The Plan contracts with individuals and entities (Business Associates) to perform various functions on its behalf. In performance of these functions or to provide services, Business Associates will receive, create, maintain, use, or disclose PHI, but only after the Plan and the Business Associate agree in writing to contract terms requiring the Business Associate to appropriately safeguard the Plan Participant's information.

3. Other Covered Entities: The Plan may disclose PHI to assist health care Providers in connection with their treatment or payment activities or to assist other covered entities in connection with payment activities and certain health care operations. For example, the Plan may disclose PHI to a health care Provider when needed by the Provider to render treatment to a Plan Participant, and the Plan may disclose PHI to another covered entity to conduct health care operations. The Plan may also disclose or share PHI with other insurance carriers (such as Medicare, etc.) in order to coordinate benefits, if a Plan Participant has coverage through another carrier.

Other Permissible Uses and Disclosures of PHI

1. Required by Law: The Plan may use or disclose PHI when required by law, provided the use or disclosure complies with and is limited to the relevant requirements of such law.

2. Public Health and Safety: The Plan may use or disclose PHI when permitted for purposes of public health activities, including disclosures to:

    (a) a public health authority or other appropriate government authority authorized by law to receive reports of child abuse, neglect or domestic violence;
    (b) report reactions to medications or problems with products or devices regulated by the Federal Food and Drug Administration or other activities related to quality, safety, or effectiveness of FDA-regulated products or activities;
    (c) locate and notify persons of recalls of products they may be using; and
    (d) a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition, if authorized by law.

3. The Plan may disclose PHI to a government authority, except for reports of child abuse or neglect permitted by (5) above, when required or authorized by law, or with the Plan Participant's agreement, if the Plan

reasonably believes he/she to be a victim of abuse, neglect, or domestic violence. In such case, the Plan will promptly inform the Plan Participant that such a disclosure has been or will be made unless the Plan believes that informing him/her would place him/her at risk of serious harm (but only to someone in a position to help prevent the threat). Disclosure generally may be made to a minor's parents or other representatives although there may be circumstances under Federal or State law when the parents or other representatives may not be given access to the minor's PHI.

4. Health Oversight Activities: The Plan may disclose PHI to a health oversight agency for oversight activities authorized by law. This includes civil, administrative or criminal investigations; inspections; claim audits; licensure or disciplinary actions; and other activities necessary for appropriate oversight of a health care system, government health care program, and compliance with certain laws.

5. Lawsuits and Disputes: The Plan may disclose PHI when required for judicial or administrative proceedings. For example, the Plan Participant's PHI may be disclosed in response to a subpoena, discovery requests, or other required legal processes when the Plan is given satisfactory assurances that the requesting party has made a good faith attempt to advise the Plan Participant of the request or to obtain an order protecting such information, and done in accordance with specified procedural safeguards.

6. Law Enforcement: The Plan may disclose PHI to a law enforcement official when required for law enforcement purposes concerning identifying or locating a suspect, fugitive, material witness or missing person. Under certain circumstances, the Plan may disclose the Plan Participant's PHI in response to a law enforcement official's request if he/she is, or are suspected to be, a victim of a crime and if it believes in good faith that the PHI constitutes evidence of criminal conduct that occurred on the Sponsor's or Plan's premises.

7. Decedents: The Plan may disclose PHI to a coroner, funeral director or medical examiner for the purpose of identifying a deceased person, determining a cause of death or as necessary to carry out their duties as authorized by law. The Plan may also disclose, as authorized by law, PHI to organizations that handle organ, eye, or tissue donation and transplantation.

8. Research: The Plan may use or disclose PHI for research, subject to certain limited conditions.

9. To Avert a Serious Threat to Health or Safety: The Plan may disclose PHI in accordance with applicable law and standards of ethical conduct, if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a threat to health or safety of a person or to the public.

10. Workers' Compensation: The Plan may disclose PHI when authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

11. Inmates: The Plan may disclose PHI when to the correctional institution or law enforcement official for: the institution to provide health care to the Plan Participant; the Plan Participant's health and safety and the health and safety of others; or the safety and security of the correctional institution.

12. Military and National Security: The Plan may disclose PHI to military authorities of armed forces personnel under certain circumstances. As authorized by law, the Plan may disclose PHI required for intelligence, counter-intelligence, and other national security activities to authorized Federal officials.

13. Emergency Situations: The Plan may disclose PHI in an emergency situation, or if the Plan Participant is incapacitated or not present, to a family member, close personal friend, authorized disaster relief agency, or any other person previously identified by you. The Plan will use professional judgment and experience to determine if the disclosure is in the Plan Participant's best interest. If the disclosure is in the Plan Participant's best interest, the Plan will disclose only the PHI that is directly relevant to the person's involvement in the Plan Participant's care.

14. Fundraising Activities: The Plan may disclose PHI for fundraising activities, such as raising money for a charitable foundation or similar entity to help finance its activities. If the Plan does not contact the Plan Participant for fundraising activities, the Plan will give the Plan Participant the opportunity to opt-out, or stop, receiving such communications in the future.

15. Group Health Plan Disclosures: The Plan may disclose PHI to a sponsor of the group health plan – such as an employer or other entity – that is providing a health care program to the Plan Participant. The Plan can disclose PHI to that entity if that entity has contracted with the Plan to administer the Plan Participant's health care program on its behalf.

16. Underwriting Purposes: The Plan may disclose PHI for underwriting purposes, such as to make a determination about a coverage application or request. If the Plan does not disclose the Plan Participant's PHI for underwriting purposes, the Plan is prohibited from using or disclosing in the underwriting process the PHI that is genetic information.

Uses and Disclosures of PHI that Require Authorization

1. Sale of PHI: The Plan will request written authorization before it makes any disclosure that is deemed a sale of PHI, meaning the Plan is receiving compensation for disclosing the PHI in that manner.

2. Marketing: The Plan will request written authorization to use or disclose PHI for marketing purposes with limited exceptions, such as when the Plan has face-to-face marketing communications with the Plan Participant or when the Plan provides promotional gifts of nominal value.

3. Psychotherapy Notes: The Plan will request written authorization to use or disclose any of the Plan Participant's psychotherapy notes that may be on file with limited exception, such as for certain treatment, payment or health care operation functions.

Other uses and disclosures of PHI that are not described above will be made only with written authorization. If the Plan Participant provides the Plan with such authorization, it may be revoked in writing and the revocation will be effective for future uses and disclosures of PHI. However, the revocation will not be effective for information that the Plan already used or disclosed, relying on the authorization.

Required Disclosures of PHI

1. Disclosures to Plan Participants: The Plan is required to disclose to a Plan Participant most of the PHI in a Designated Record Set when the Plan Participant requests access to this information. The Plan will disclose a Plan Participant's PHI to an individual who has been assigned as his/her representative and who has qualified for such designation in accordance with the relevant State law. Before disclosure to an individual qualified as a personal representative, the Plan must be given written supporting documentation establishing the basis of the personal representation.

   The Plan may elect not to treat the person as the Plan Participant's personal representative if it has a reasonable belief that the Plan Participant has been, or may be, subjected to domestic violence, abuse, or neglect by such person, it is not in the Plan Participant's best interest to treat the person as his/her personal representative, or treating such person as his/her personal representative could endanger the Plan Participant.

2. Disclosures to the Secretary of the U.S. Dept of Health and Human Services: The Plan is required to disclose the Plan Participant's PHI to the Secretary of the U.S. Department of Health and Human Resources when the Secretary is investigating or determining the Plan's compliance with the HIPAA Privacy Rule.

3. Business Associates: The Plan contracts with individuals and entities (Business Associates) to perform various functions on its behalf. In performance of these functions or to provide services, Business

Associates will receive, create, maintain, use, or disclose PHI, but only after the Plan and the Business Associate agree in writing to contract terms requiring the Business Associate to appropriately safeguard the Plan Participant's information.

4. Other Covered Entities: The Plan may disclose PHI to assist health care Providers in connection with their treatment or payment activities or to assist other covered entities in connection with payment activities and certain health care operations. For example, the Plan may disclose PHI to a health care Provider when needed by the Provider to render treatment to a Plan Participant, and the Plan may disclose PHI to another covered entity to conduct health care operations. The Plan may also disclose or share PHI with other insurance carriers (such as Medicare, etc.) in order to coordinate benefits, if a Plan Participant has coverage through another carrier.

Potential Impact of State Law

The HIPAA Privacy Rule regulations generally do not "preempt" (or take precedence over) state privacy or other applicable laws that provide individuals greater privacy protections. As a result, to the extent state law applies, the privacy laws of a particular state, or other federal laws, rather than the HIPAA Privacy Rule regulations, might impose a privacy standard under which the Plan will be required to operate. For example, where such laws have been enacted, the Plan will follow more stringent state privacy laws that relate to uses and disclosures of PHI concerning HIV or AIDS, mental health, substance abuse/chemical dependency, genetic testing, reproductive rights, etc.

Rights to Individuals

The Plan Participant has the following rights regarding PHI about him/her:

1. Request Restrictions: The Plan Participant has the right to request additional restrictions on the use or disclosure of PHI for treatment, payment, or health care operations. The Plan Participant may request the Plan restrict disclosures to family members, relatives, friends or other persons identified by him/her who are involved in his/her care or payment for his/her care. The Plan is not required to agree to these requested restrictions.

2. Right to Receive Confidential Communication: The Plan Participant has the right to request that he/she receive communications regarding PHI in a certain manner or at a certain location. The request must be made in writing and how the Plan Participant would like to be contacted. The Plan will accommodate all reasonable requests.

3. Copy of this Notice: The Plan Participant is entitled to receive a paper copy of this notice at any time. To obtain a paper copy, contact the Privacy Compliance Coordinator.

4. Accounting of Disclosures: The Plan Participant has the right to request an accounting of disclosures the Plan has made of his/her PHI. The request must be made in writing and does not apply to disclosures for treatment, payment, health care operations, and certain other purposes. The Plan Participant is entitled to such an accounting for the six (6) years prior to his/her request, though not earlier than April 14, 2003. Except as provided below, for each disclosure, the accounting will include: (a) the date of the disclosure, (b) the name of the entity or person who received the PHI and, if known, the address of such entity or person; (c) a description of the PHI disclosed, (d) a statement of the purpose of the disclosure that reasonably informs the Plan Participant of the basis of the disclosure, and certain other information. If the Plan Participant wishes to make a request, please contact the Privacy Compliance Coordinator.

5. Access: The Plan Participant has the right to request the opportunity to look at or get copies of PHI maintained by the Plan about him/her in certain records maintained by the Plan. If the Plan Participant requests copies, he/she may be charged a fee to cover the costs of copying, mailing, and other supplies. To inspect or copy PHI contact the Privacy Compliance Coordinator. In very limited circumstances, the Plan

may deny the Plan Participant's request. If the Plan denies the request, the Plan Participant may be entitled to a review of that denial.

6. Amendment: The Plan Participant has the right to request that the Plan change or amend his/her PHI. The Plan reserves the right to require this request be in writing. Submit the request to the Privacy Compliance Coordinator. The Plan may deny the Plan Participant's request in certain cases, including if it is not in writing or if he/she does not provide a reason for the request.

Questions or Complaints

If the Plan Participant wants more information about the Plan's privacy practices, has questions or concerns, or believes that the Plan may have violated his/her privacy rights, please contact the Plan using the following information. The Plan Participant may submit a written complaint to the U.S. Department of Health and Human Services or with the Plan. The Plan will provide the Plan Participant with the address to file his/her complaint with the U.S. Department of Health and Human Services upon request.

The Plan will not retaliate against the Plan Participant for filing a complaint with the Plan or the U.S. Department of Health and Human Services.

Contact Information:

Privacy Compliance Coordinator Contact Information:

Gilster Mary Lee Corporation
P.O. Box 227
Chester, IL 62233
618-826-2361
618-826-2973

ARTICLE XIX
HIPAA SECURITY

Disclosure of Electronic Protected Health Information ("Electronic PHI") to the Plan Sponsor for Plan Administration Functions

STANDARDS FOR SECURITY OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION ("SECURITY RULE")

The Security Rule imposes regulations for maintaining the integrity, confidentiality and availability of protected health information that it creates, receives, maintains, or maintains electronically that is kept in electronic format (ePHI) as required under the Health Insurance Portability and Accountability Act (HIPAA).

Definitions;

"Electronic Protected Health Information" (ePHI) is defined in Section 160.103 of the Security Standards (45 C.F.R. 160.103) and means individually identifiable health information transmitted or maintained in any electronic media.

"Security Incidents" is defined within Section 164.304 of the Security Standards (45 C.F.R. 164.304) and means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operation in an information system.

Plan Sponsor Obligations

To enable the Plan Sponsor to receive and use Electronic PHI for Plan Administration Functions (as defined in 45 CFR §164.504(a)), the Plan Sponsor agrees to:

1. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan.

2. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in 45 CFR § 164.504(f)(2)(iii), is supported by reasonable and appropriate Security Measures.

3. Ensure that any agent, including a subcontractor, to whom the Plan Sponsor provides Electronic PHI created, received, maintained, or transmitted on behalf of the Plan, agrees to implement reasonable and appropriate report to the Plan any security incident of which it becomes aware.

4. Report to the Plan any security incident of which it becomes aware.

Notification Requirements in the Event of a Breach of Unsecured PHI

The required breach notifications are triggered upon the discovery of a breach of unsecured PHI. A breach is discovered as of the first day the breach is known, or reasonably should have been known.

When a breach of unsecured PHI is discovered, the Plan will:

1. Notify the individual whose PHI has been, or is reasonably believed to have been, assessed, acquired, used, or disclosed as a result of the breach, in writing, without unreasonable delay and in no case later than 60 calendar days after discovery of the breach.

2. Notify the media if the breach affected more than 500 residents of a State or jurisdiction. Notice must be provided to prominent media outlets serving the State or jurisdiction without unreasonable delay and in no case later than 60 calendar days after the date the breach was discovered.

3. Notify the HHS Secretary if the breach involves 500 or more individuals, contemporaneously with the notice to the affected individual and in the manner specified by HHS. If the breach involves less than 500 individuals, an internal log or other documentation of such breaches must be maintained and annually submitted to HHS within 60 days after the end of each calendar year.

4. When a Business Associate, which provides services for the Plan and comes in contact with PHI in connection with those services discovers a breach has occurred, that Business Associate will notify the Plan without unreasonable delay and in no case later than 60 calendar days after discovery of a breach so that the affected individuals may be notified. To the extent possible, the Business Associate should identify each individual whose unsecured PHI has been, or is reasonably believed to have been, breached.

Any terms not otherwise defined in this section shall have the meanings set forth in the Security Standards.

ARTICLE XX
PARTICIPANT'S RIGHTS

As a Participant in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan Participants are entitled to:

Receive Information About Your Plan and Benefits
Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls (if any), all documents governing the Plan, including insurance contracts, collective bargaining agreements (if any), and copies of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements (if any), and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

Continue Group Health Plan Coverage
Continue health care coverage for yourself, spouse or Dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. You or your Dependents may have to pay for such coverage. Review this Plan Document and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries
In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and beneficiaries. No one, including your Employer, your union (if any), or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights
If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a State or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a Medical Child Support Order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who would pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions
If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the

Plan Administrator, you should contact the nearest Office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C., 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.